1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13862

CERTIFICATE OF DEATH

13796

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Monte.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: ?

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4835 Langdrum Lane

d. STREET ADDRESS: 4835 Langdrum Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Herbert Middle: F. Last: Aldridge

4. DATE OF DEATH: Month: December Day: 12, Year: 19 59

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/26/1892
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired, Lithographer
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (State or foreign country): Conn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Thomas Aldridge
14. MOTHER'S MAIDEN NAME: Augusta Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
INFORMANT: wife Address: Chevy Chase, Md.
Olive R. Aldridge, 4835 Langdrum Lane,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: At death
420.0
DUE TO (b) Arteriosclerotic Heart Disease — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1946, 19, to 12/12, 1959 that I last saw the deceased alive on 12/6, 1959, and that death occurred at 10:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Latimer Jr. M.D. ADDRESS (Street, city or town, state): 1728 Mass Ave N.W. Washington DC DATE SIGNED: 12/12/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): burial
22b. DATE THEREOF: 12/15/59
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Pr. Geo. Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co., ADDRESS: 2901 14th St. N.W. Wash, D.C.
24a. REC'D BY REGISTRAR DATE: DEC 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13868

CERTIFICATE OF DEATH

Reg. Dist. No. 13797

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b: Since Dec. 8, 1959
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENSINGTON GARDENS REST HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47X-3
d. STREET ADDRESS: 7701 GEORGIA AVENUE, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDGAR — Middle RICHBELL — Last ALLABAND
4. DATE OF DEATH: Month DEC. — Day 11 — Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/27/72
9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHARMACIST (retired)
10b. KIND OF BUSINESS OR INDUSTRY: Retail Druggist
11. BIRTHPLACE (State or foreign country): DELAWARE
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM R. ALLABAND
14. MOTHER'S MAIDEN NAME: MARY KINNEY
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-24-8593
17. INFORMANT: Mrs. Emma C. Allaband, 7701 Ga. Ave., N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.
422.1
DUE TO (b): Arterio sclerotic cardiovascular disease — 8 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 26, 1959, to December 10, 1959, that I last saw the deceased alive on December 9, 1959, and that death occurred at 1:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R Coleman M.D. — M.D. — ADDRESS (Street, city or town, state): 733 Sligo Avenue Silver Spring Md. — DATE SIGNED: 12/14/59

PHYSICIAN'S NAME (Type): JAMES R. COLEMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/14/59
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Zeska — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE DEC 16 '59
24b. REGISTRAR'S SIGNATURE: Eldon S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13854

Reg. Dist. No. 13798

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL SILVER SPRING
c. LENGTH OF STAY IN 1b: 1 yr.,2 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MARILEA NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING
d. STREET ADDRESS: 8819 Second Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JERUSHA — Middle — Last ANNADALE

4. DATE OF DEATH: Month DECEMBER — Day 27 — Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 11/26/80

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert L. Nash

14. MOTHER'S MAIDEN NAME: Susan Poor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Geo. H. Manning, 8819 2nd Ave., Silver Spring, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2-3 yrs
450.0
DUE TO
(b) Arteriosclerosis — ?
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1958, to 27 Dec, 1959, that I last saw the deceased alive on 22 Dec, 1959, and that death occurred at 8:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William D. Aud M.D. — ADDRESS (Street, city or town, state): 9006 Colesville Rd Silver Spring Md — DATE SIGNED: 12/27/59

PHYSICIAN'S NAME (Type): WILLIAM D. AUD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12/30/59

22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY

22d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Fiska — ADDRESS: WARNER E. PUMPHREY, INC. SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: DEC 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13865

CERTIFICATE OF DEATH

13799

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Norfolk
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norfolk — 83x-3
d. STREET ADDRESS: 453 Walk Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: THEODORE; Middle: ROOSEVELT; Last: ARTIS, JR.

4. DATE OF DEATH: Month: DECEMBER; Day: 10; Year: 19 59

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 6, 1945
9. AGE (In years last birthday): 14 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Theodore R. Artis, Sr.
14. MOTHER'S MAIDEN NAME: Bessie Gray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis, Lungs, Post Operative — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
754.5
DUE TO
(b) Atrioventricular Canal — Congenital
DUE TO
(c) Mitral Insufficiency

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 15, 19 59, to December 10, 19 59, that I last saw the deceased alive on December 10, 19 59, and that death occurred at 4:12 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Roland Folse, MD M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 12-11-59
PHYSICIAN'S NAME (Type): ROLAND FOLSE, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 12-11-59
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State): Norfolk, Va.

23. FUNERAL-DIRECTOR'S SIGNATURE: Frazier's Funeral Home Inc.
ADDRESS: 384-R.I. Ave N.W. D.C.
24a. REC'D BY REGISTRAR: DATE DEC 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13866

CERTIFICATE OF DEATH

Reg. Dist. No. 13800

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 162 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park 16 17-2
d. STREET ADDRESS: 7219 Spruce Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Patricia — Middle: Elaine — Last: Atler

4. DATE OF DEATH: Month: December — Day: 1 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 29 January 1952
9. AGE (In years last birthday): 7 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry D. Atler, Jr.
14. MOTHER'S MAIDEN NAME: Margaret Barnett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Wilms's Tumor with extensive involvement of lungs, — INTERVAL BETWEEN ONSET AND DEATH: 15 months
DUE TO liver and pancreas
180 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Bronchopneumonia — unknown
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 22, 19 59, to December 1, 19 59 that I last saw the deceased alive on December 1, 19 59, and that death occurred at 1:25 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur R Rothman M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED: 12/1/59

PHYSICIAN'S NAME (Type): Arthur R. Rothman M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec 4 1959
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St NW DC
24a. REC'D BY REGISTRAR: DATE DEC 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13867

CERTIFICATE OF DEATH

Reg. Dist. No. 215 13801

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairfax 83X-3
d. STREET ADDRESS: 1601 East Lee Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

051

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: George; Last: Jr. BARNA
4. DATE OF DEATH: Month: December; Day: 1; Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-19-59
9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months: ; Days: 12 IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Joseph George Barna Sr.
14. MOTHER'S MAIDEN NAME: Jacqueline OSTRANDER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
INFORMANT: (Father) Joseph G. Barna Address: Same as #2

1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH
570.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 26 November, 19 59, to 1 December, 1959, that I last saw the deceased alive on 1 December, 19 59, and that death occurred at 1:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W.D. Hoofer M.D. ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda Md. DATE SIGNED: 12-2-59

1

PHYSICIAN'S NAME (Type): W.D. HOOFER LT MC USN U.S. Naval Hospital, NNMC, Bethesda Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-4-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE: R.A. Pumphrey ADDRESS: 7557 Wisconsin Ave. Bethesda Md.
24a. REC'D BY REGISTRAR DATE DEC 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

2051212XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13802

Reg. Dist. No.

~~13868~~

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood R-1
c. LENGTH OF STAY IN 1b: 1½ yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Redland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood R-1
d. STREET ADDRESS: Redland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virgil — Middle: Clark — Last: Barnhouse
4. DATE OF DEATH: Month: Dec — Day: 25 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 22 1911
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ernest C. Barnhouse
14. MOTHER'S MAIDEN NAME: Mary C. Copper
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-16-9742
17. INFORMANT: Esther May Barnhouse (wife) — Address: Route 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudd death witnessed
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-25-59
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 28, 1959
22c. NAME OF CEMETERY OR CREMATORY: Laytonsville Meth. Cem.
22d. LOCATION (City, town, or county) (State): Laytonsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber — ADDRESS: Laytonsville, Md.
24a. REC'D BY REGISTRAR DATE: DEC 31 59
24b. REGISTRAR'S SIGNATURE: Arthur S. Trama

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13826

CERTIFICATE OF DEATH

Reg. Dist. No. 13803

1. PLACE OF DEATH a. COUNTY: MONTGOMERY MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park Md.

c. LENGTH OF STAY IN 1b: 3 Yrs

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Shannon Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: WASH b. COUNTY: D.C.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C. 47 x-3

d. STREET ADDRESS: 949 Longfellow St, N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

090

3. NAME OF DECEASED (Type or print): First Grace Middle Virginia Last Beard.

4. DATE OF DEATH Month 12 Day 5 Year 59

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 9/2/1875

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Leesburg Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Gheen

14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Bertie M Caffrey, Address: 949 Longfellow St N.,W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1-2 yrs

450.0

DUE TO (b) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 19 56 to 5 Dec 19 59, that I last saw the deceased alive on 4 Dec 19 59, and that death occurred at 5:06 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William D Lind M.D. ADDRESS (Street, city or town, state): 9 Nb Colesville Rd DATE SIGNED: 12/5/59

PHYSICIAN'S NAME (Type): Silver Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/8/59

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Pr Georges Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. K. Huntemann & Son

ADDRESS: 5732 Georgia Ave N.W.

24a. REC'D BY REGISTRAR DATE DEC 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13867 — Reg. Dist. No. 13804

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg - R-2
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Emory Grove

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg R-2
d. STREET ADDRESS: Emory Grove
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Roosevelt — Last: Bell Jr

4. DATE OF DEATH: Month: Dec — Day: 25 — Year: 1959

5. SEX: male
6. COLOR OR RACE: colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 24, 1959
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur R. Bell
14. MOTHER'S MAIDEN NAME: Mary Neal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Bell (mother) — Address: Stem 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Upper Respiratory Infection
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

475X

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-25-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/27/59
22c. NAME OF CEMETERY OR CREMATORY: Emory Grove.,
22d. LOCATION (City, town, or county) (State): Emory Grove, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Swadley
ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR — DATE: DEC 29 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13827

CERTIFICATE OF DEATH

Reg. Dist. No. 13805

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Oak Haven Rest Home 517 Albany Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DC
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 1920 Park Road, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary — Middle Frances — Last Bode

4. DATE OF DEATH: Month December — Day 3, — Year 1959

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/9/1866
9. AGE (In years last birthday): 93 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Kaltenbach
14. MOTHER'S MAIDEN NAME: Wilhelmenia Hockenheimer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
INFORMANT: Oak Haven Rest Home — Address: 517 Albany Avenue Takoma Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO
(b) Pneumonia, lobar. — 2 days.
DUE TO
(c) Cardio vascular decompensation & arteriosclerosis — 1 yr.

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Age

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year 19 — Hour a. m. p. m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from July, 1952, to Dec 3, 1959, that I last saw the deceased alive on 12/2/59, 19____, and that death occurred at 6:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 4301 48th St. NW — DATE SIGNED: 12/3/59

PHYSICIAN'S NAME (Type): S. A. Thomas MD — Washington D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 12/5/59
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR: DATE DEC 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13806

13870

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENSINGTON GARDENS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 502 DOMER AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle FREDERICK Last BOETTCHER
4. DATE OF DEATH: Month Dec. Day 14 Year 1959
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-14-72
9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MUSICIAN US MARINE BAND Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wash DC
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jachim Boettcher
14. MOTHER'S MAIDEN NAME: Mary Engle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Retired 1937
16. SOCIAL SECURITY NO.: —
INFORMANT: Albert G. Ostermann — Address: 502 Domer Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion. — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
420.1
DUE TO
(b) Coronary arteriosclerosis — ?
DUE TO
(c) Generalized arteriosclerosis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes, amputated both legs.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan., 1958, to Dec. 14, 1959, that I last saw the deceased alive on December 9, 1959, and that death occurred at 12:10 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter K. Angerine, M.D. — ADDRESS (Street, city or town, state): 6300 13th St, NW, Wash. 11, DC — DATE SIGNED: 12/14/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-16-59
22c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cem
22d. LOCATION (City, town, or county) (State): Washington DC

23. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: 4812 Ga Ave NW
24a. REC'D BY REGISTRAR DATE DEC 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

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13823

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13807

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reti[illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San. and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 1232 Dale Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Silas; Middle: Edward; Last: Booth

4. DATE OF DEATH: Month: Dec.; Day: 25; Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-22-83
9. AGE (In years lost birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Agriculture Dept.
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Booth
14. MOTHER'S MAIDEN NAME: Mary Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
INFORMANT: Mrs. Sarah M. Booth, 232 Dale Drive, Silver Spring, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary artery insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 13 days.
420.0
DUE TO (b) Arteriosclerotic heart disease, coronary — 13 days.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) thrombosis and myocardial infarction

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Calcific aortitic stenosis
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1959, to Dec 25, 1959, that I last saw the deceased alive on December 29, 1959, and that death occurred at 9:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Aaron H. Traum M.D. ADDRESS (Street, city or town, state): 8237 Georgia Ave Silver Spring Md DATE SIGNED: Dec 25 59.
PHYSICIAN'S NAME (Type): Aaron H. Traum

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 29, 1959
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeba — ADDRESS: Warner E. Pumphrey, Inc., Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: DEC 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Krause

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13871

Reg. Dist. No. 13808

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7205-46th. Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase
d. STREET ADDRESS 7205-46th. Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Harry Middle: Simonds Last: Boteler, Jr.
4. DATE OF DEATH Month: December Day: 27 Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-17-97
9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR: Months 0 Days 10 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney
10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry S. Boteler, Sr.
14. MOTHER'S MAIDEN NAME: Amelia Hess

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 578-01-2235
INFORMANT: Zella N. Boteler- Item #2 - Wife Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.
420.1
DUE TO
(b) Myocardial Infarction — 8 mos
DUE TO
(c) Coronary Artery Sclerosis — 7 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 2, 1958 to Dec 27, 1959 that I last saw the deceased alive on Dec 24, 1959, and that death occurred at 6:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert Mitchell M.D. ADDRESS (Street, city or town, state): 5516 Nebraska Ave DC DATE SIGNED: 12/27/59
PHYSICIAN'S NAME (Type): Robert B. Havell

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-29-59
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE DEC 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1

M

074

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13872

CERTIFICATE OF DEATH

Reg. Dist. No. 13809

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Spencerville
d. STREET ADDRESS: 1 Batson Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First William, Middle G., Last BOWEN
4. DATE OF DEATH: Month 12, Day 15, Year 1959
5. SEX: Male
6. COLOR OR RACE: C.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 29, 1902
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian
10b. KIND OF BUSINESS OR INDUSTRY: John Hopkins Lab.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William George Bowen
14. MOTHER'S MAIDEN NAME: Boston
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: Yes?
INFORMANT: Stephen, Edward Lee — Address: Bishop. Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: weeks
DUE TO (b) Myocardial Insufficiency — weeks
DUE TO (c) Aortic Insufficiency — Unknown
421.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-15, 1959, to 12-15, 1959 that I last saw the deceased alive on 12-15, 1959, and that death occurred at 7:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John S. Cogan M.D. — ADDRESS (Street, city or town, state): 19 19 Lemington Rd. — DATE SIGNED: 12-16-59
PHYSICIAN'S NAME (Type): [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/19/59
22c. NAME OF CEMETERY OR CREMATORY: Ebenezer Church.
22d. LOCATION (City, town, or county) (State): Ashton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE DEC 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13878

CERTIFICATE OF DEATH

Reg. Dist. No. 13810

M

073

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 49 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY COUNTY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X GERMANTOWN
d. STREET ADDRESS: RFD #2 BOX #5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CHARLES — Middle: ALVIN — Last: BOYER

4. DATE OF DEATH: Month: DECEMBER — Day: 3 — Year: 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4/13/89

9. AGE (In years lost birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer-Owner

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: WESTLY BOYER

14. MOTHER'S MAIDEN NAME: ----- Sarah C. Day

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT: HOSPITAL RECORDS — Address: OLNEY, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1. Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO 2. Gastro-Intestinal Hemorrhage — 3 weeks
(b) Severe, Due to Congenital Telangiectasia — 2 weeks
DUE TO (c) 3. Urinary Retention, due

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 15, 19 59, to Dec. 5, 19 59, that I last saw the deceased alive on Dec. 3, 19 59, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Jack Schumacher M.D. — ADDRESS (Street, city or town, state): GAITHERSBURG, MARYLAND — DATE SIGNED: 12-4-59

PHYSICIAN'S NAME (Type): J. SCHUMACHER, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/6/59

22c. NAME OF CEMETERY OR CREMATORY: Darnestown

22d. LOCATION (City, town, or county) (State): Darnestown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Tyson Wheeler Funeral Home-1331 E. Montg. Ave., Rockville, Md.

24a. REC'D BY REGISTRAR — DATE: DEC 7 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13829

Reg. Dist. No. 13811

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 1812 Powder Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harold Middle Lee Last Briggs, SR.
4. DATE OF DEATH: Month 12 Day 17 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-12-07
9. AGE (In years lost birthday): 52 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): attorney fed. Trade Commission
10b. KIND OF BUSINESS OR INDUSTRY: Review
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY? U.S.a

13. FATHER'S NAME: Other B. Briggs
14. MOTHER'S MAIDEN NAME: Florence Mc Millan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): none (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
INFORMANT: Mrs. Ann A. Briggs, wife — Address: 1812 Powder Mill Road, Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 11 days
420.1
DUE TO
(b) Coronary Thrombosis — 11 days
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 15, 1956, to Dec 17, 1959, that I last saw the deceased alive on Dec 16, 1959, and that death occurred at 7:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James M. Whitlock M.D. — ADDRESS (Street, city or town, state): 7201 Carroll Ave Takoma Park 12 Maryland — DATE SIGNED: 12-17-59

PHYSICIAN'S NAME (Type): JAMES M. WHITLOCK

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/20/59
22c. NAME OF CEMETERY OR CREMATORY: Geo. Wash. Mem. Cemetery
22d. LOCATION (City, town, or county) (State): Prince Geo. County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Sisko — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR — DATE: DEC 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13874

Reg. Dist. No. 13812

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3923 Denfeld Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie; Middle: June; Last: Brooke
4. DATE OF DEATH: Month: 12; Day: 17; Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/29/86
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Housewife~~ Clerk (retired)
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Treasury
11. BIRTHPLACE (State or foreign country): Nebraska, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Isaac N. G ibbs
14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Eva M. Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-50-6539
INFORMANT: Son (John T. Brooke) Item #2 — Address

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cereberal Infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 DAYS
332x
DUE TO
(b): Cereberal artery Thrombosis — 18 DAYS
DUE TO
(c): Cereberal arteriosclerosis — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Aneurysm circle of Willis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 30, 1957, to Dec 17, 1959, that I last saw the deceased alive on Dec 17, 1959, and that death occurred at 9 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Michael R. Dobridge, M.D. — ADDRESS (Street, city or town, state): 10620 Georgia Ave Silver Spring, Md — DATE SIGNED
PHYSICIAN'S NAME (Type): Michael R. Dobridge

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/19/59
22c. NAME OF CEMETERY OR CREMATORY: CONGRESSIONAL CEMETERY
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Liska — WARNER E. PUMPHREY, INC. — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR — DATE: DEC 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 7 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13875

CERTIFICATE OF DEATH

13813

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Alexandria
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 83x-3
d. STREET ADDRESS: 219 East Belleforte Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First: Basil; Middle: Henry; Last: Buchanan
4. DATE OF DEATH: Month: December; Day: 6; Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: August 28, 1916
9. AGE (In years last birthday): 43 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Taxi Cab Driver
10b. KIND OF BUSINESS OR INDUSTRY: Transportation
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Alex Buchanan
14. MOTHER'S MAIDEN NAME: Ewrie Angle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 233-07-6624
INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

420.1

DUE TO
(b) Calcific aortic dilatation — 5-10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO
(c) Coronary arteriosclerosis and generalized arteriosclerosis — 5-10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic cholecystitis and cholelithiasis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from November 29, 1959, to December 6, 1959 that I last saw the deceased alive on December 6, 1959, and that death occurred at 7:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John T. Potts Jr. M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 12/6/59
PHYSICIAN'S NAME (Type): John T. Potts, Jr. M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 12/7/59
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): JAEGER, WEST, VA.
23. FUNERAL DIRECTOR'S SIGNATURE: W. B. Mountcastle — ADDRESS: ALEXANDRIA VA — CUNNINGHAM FUNERAL HOME
24a. REC'D BY REGISTRAR: DATE DEC 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13876

CERTIFICATE OF DEATH

Reg. Dist. No. 13814

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 3-MONS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll Hall-Sant.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PR. GEO!
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON 16X-2
d. STREET ADDRESS: #5-Horseshoe Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY; Middle: A.; Last: CADELL
4. DATE OF DEATH: Month: DECEMBER; Day: 30; Year: 1959
5. SEX: Female
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 14 1885
9. AGE (In years lost birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Phil. Pa.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: John McKay
14. MOTHER'S MAIDEN NAME: MARY A. McElhatton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
INFORMANT: Agnes B. Luskey — Address: #5-Horseshoe Rd Clinton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS
420.0
DUE TO
(b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(c) GENERALIZED ARTERIOSCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SENILITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from SEPT. 12, 1959, to DEC. 30, 1959, that I last saw the deceased alive on DEC. 30, 1959, and that death occurred at 7:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Herman Fowler M.D. — ADDRESS (Street, city or town, state): 5206 Norway Dr. — DATE SIGNED: 12-30-59

PHYSICIAN'S NAME (Type): Cherry Chase Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-2-1960
22c. NAME OF CEMETERY OR CREMATORY: Washington Natl.
22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bro. — ADDRESS: 1661-Good Hope Rd SE Wash. 20 DC
24a. REC'D BY REGISTRAR: DATE DEC 31 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, give the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SB

X1 X

13830

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13815

M

075

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re[illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 10112 Pierce Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Joseph — Last: Campbell

4. DATE OF DEATH: Month: Dec. — Day: 15 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 10-18-82

9. AGE (In years lost birthday): 77 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Plate Printer

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Campbell

14. MOTHER'S MAIDEN NAME: Catherine Claney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Old Records in Hospital — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
420.1
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 11, 1959, to Dec. 15, 1959, that I last saw the deceased alive on Dec. 14, 1959, and that death occurred at 7:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE A. F. Thibadeau M.D. — **ADDRESS** (Street, city or town, state): 10111 Celesville Rd. — **DATE SIGNED**

PHYSICIAN'S NAME (Type) A.F. Thibadeau — Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 12/17/59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. — **ADDRESS**: 2901-14th St. N.W. Washington, D.C.

24a. REC'D BY REGISTRAR — DATE: DEC 17 '59

24b. REGISTRAR'S SIGNATURE: Graham S. Kraus

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG254 1-4-60 et

13831

CERTIFICATE OF DEATH

Reg. Dist. No. 13816

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7516 CARROLL AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 TAKOMA PARK
d. STREET ADDRESS: 7516 CARROLL AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: MARY; Middle:; Last: CANAVAN

4. DATE OF DEATH: Month: DEC.; Day: 26; Year: 1959.

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 17, 1882

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: ; Days: . IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): ENGLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARTIN CHAMBERS

14. MOTHER'S MAIDEN NAME: CATHERINE NOLAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MR JAMES CANAVAN, Address: 7516 CARROLL AVE., TAKOMA PARK, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
434.1
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr, 1946, to 26 Dec, 1959, that I last saw the deceased alive on 26 Dec, 1959, and that death occurred at 10 45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H B Queen M.D.
ADDRESS (Street, city or town, state): 7112 Willow Ave
DATE SIGNED: 26 Dec 1959.

PHYSICIAN'S NAME (Type): H. B. QUEEN Takoma Park Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: DEC. 1959
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY
22d. LOCATION (City, town, or county) (State): BLADENSBURG Rd, PR. GEO. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Herbert Walker
ADDRESS: 254 CARROLL ST. N.W. D.C.

24a. REC'D BY REGISTRAR DATE: DEC 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13877

CERTIFICATE OF DEATH

Reg. Dist. No. 13817

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Bethesda~~ Chevy Chase
c. LENGTH OF STAY IN 1b: 10 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4710 Hunt Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Bethesda~~ Chevy Chase
d. STREET ADDRESS: 4710 Hunt Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARK — Middle E. — Last CARRIER

4. DATE OF DEATH: Month Dec. — Day 27, — Year 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 3, 1903
9. AGE (In years lost birthday): 56 yrs. — IF UNDER 1 YEAR: Months 4 Days 24 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Stohlman Chev.
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Carrier
14. MOTHER'S MAIDEN NAME: Pearl Kunselman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): - - - - -
16. SOCIAL SECURITY NO.: 578-05-6311
INFORMANT: Oma Carrier - Item #2 - Wife — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
420.0
DUE TO
(b) Coronary Occlusion. — 2 days.
DUE TO
(c) Arterio Sclerotic Heart Disease — 17 years+

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1942, 19__, to 12/27, 1959 that I last saw the deceased alive on 12/27, 19 59, and that death occurred at 7:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William P. Argy M.D. — ADDRESS (Street, city or town, state): 1150 Conn. Ave., N.W. — DATE SIGNED: Over

PHYSICIAN'S NAME (Type): WILLIAM P. ARGY — Washington, D. C. — 12-28-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-30-59
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
24a. REC'D BY REGISTRAR — DATE: DEC 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

Birthwt. 1 lb 6 oz.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13878

CERTIFICATE OF DEATH

Reg. Dist. No. 13818

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1310 North Van Buren St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

074

3. NAME OF DECEASED (Type or print): First: BABY Middle: GIRL Last: CARROLL
4. DATE OF DEATH: Month: DECEMBER Day: 27 Year: 1959

5. SEX: FEMALE
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/27/59
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: 1 Min.: 50

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PAUL EDWARD CARROLL
14. MOTHER'S MAIDEN NAME: IDA MAE GENIES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
INFORMANT: MOTHER Address:

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anoxemia — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hrs
762.5
DUE TO (b) Atelectasis — "
DUE TO (c) Immature premature — "

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour: a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/27, 1959 to 12/27, 1959 that I last saw the deceased alive on 12/27, 1959, and that death occurred at 11:40 p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. F. Colliton, Jr. M.D.
ADDRESS (Street, city or town, state): 809 Veirs Mill Rd
DATE SIGNED: 12/29/59
PHYSICIAN'S NAME (Type): WILLIAM F COLLITON JR MD — Rockville, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
22b. DATE THEREOF: 12-27-59
22c. NAME OF CEMETERY OR CREMATORY: Suburban Hospital
22d. LOCATION (City, town, or county) (State): 8400 Old Georgetown Rd Bethesda Md

23. FUNERAL DIRECTOR'S SIGNATURE: Suburban Hospital
ADDRESS: 8400 Old Georgetown Rd Bethesda Md
24a. REC'D BY REGISTRAR: DATE 12-29-59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus
DEC 31 '59

2074201XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13879

Reg. Dist. No. 13819

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RFD.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont'g
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: R-1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Paul — Last: Caulfield

4. DATE OF DEATH: Month: Jan — Day: 28 — Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 7-22-1902

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wm S. Caulfield

14. MOTHER'S MAIDEN NAME: Eliz. Hutton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Helen C. Madine (daughter) — Address: Stm 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Tuberculosis 2 yrs (arrested) 0021

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or **CONTRIBUTING** ☐ **CAUSE OF DEATH.**

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-28-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-30-59
22c. NAME OF CEMETERY OR CREMATORY: Ch Rose
22d. LOCATION (City, town, or county) (State): Clopper Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Brook C. Farmer — ADDRESS: Gaithersburg Md.

24a. REC'D BY REGISTRAR DATE DEC 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13820

Reg. Dist. No.

13880

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D. C. b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47x-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1800 GRACE CHURCH RD.

d. STREET ADDRESS 3610 ORDWAY ST., N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: ARTHUR Middle: W. Last: CHASE

4. DATE OF DEATH Month: Dec. Day: 5, Year: 19 59

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 10/30/1873

9. AGE (In years last birthday) 86 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. ARCHITECT

10b. KIND OF BUSINESS OR INDUSTRY U. S. NAVY

11. BIRTHPLACE (State or foreign country) COLORADO

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME REV. DEMPSTER W. CHASE

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. NONE

INFORMANT STANHOPE CHASE, Address 4844 CHAIN BRIDGE RD. McLEAN, VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) generalized arteriosclerosis — 20 yrs.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): enlarged prostate

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Jan 10, 1957, to Dec 5, 1959, that I last saw the deceased alive on 12/5, 1959, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE E H Markwood M.D. ADDRESS (Street, city or town, state) 3208 - 17 St N.W. Wash. 10. DC DATE SIGNED 12/5/59

PHYSICIAN'S NAME (Type) E.H. Markwood, M.D. 3208 17th St., N.W., WASH., D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 12/8/59

22c. NAME OF CEMETERY OR CREMATORY HOLLYWOOD CEMETERY

22d. LOCATION (City, town, or county) (State) RICHMOND, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlinski ADDRESS 1756 PA. AVE., N.W.

24a. REC'D BY REGISTRAR DATE DEC 8 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, give the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/5B

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13881

CERTIFICATE OF DEATH

Reg. Dist. No. 13821

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 days 6 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 7601 Chelton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

074

3. NAME OF DECEASED (Type or print): First: Vasilios; Middle: I.; Last: Chebithes

4. DATE OF DEATH: Month: 12; Day: 10; Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 11/15/1894

9. AGE (In years lost birthday): 65 yrs.

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney

10b. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Greece

12. CITIZEN OF WHAT COUNTRY?: Naturalized. U.S.A.

13. FATHER'S NAME: Isadore Chebithes

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1917 – 18

16. SOCIAL SECURITY NO.: 290-18-2363

INFORMANT: Julia Sapounakis — Address: 4813 Bayard Blvd. Bethesda Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IRREVERSIBLE SHOCK + TOXEMIA

578x

DUE TO (b) Massive ABDOMINAL ABSCESS;

DUE TO (c) Perforated appendix, Intestinal obstruction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: approx. 18 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): atelectasis, Lungs.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-1-, 1959, to 12-10-, 1959, that I last saw the deceased alive on 12-9-59, 19____, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Linwood H. Johnson, M.D. — **ADDRESS** (Street, city or town, state): 4630 Montgomery Ave. Bethesda, Md. — **DATE SIGNED**: 12-10-59

PHYSICIAN'S NAME (Type) Linwood H. Johnson

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-14-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY — **ADDRESS**: Bethesda, Md.

24a. REC'D BY REGISTRAR — DATE DEC 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG254 1-22-60 et

CERTIFICATE OF DEATH

13882

Reg. Dist. No. 13822

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D.C. ~~Maryland~~ b. COUNTY ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Ken~~ Washington 47X-3
d. STREET ADDRESS 5424 Nebraska Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First SOPHIE Middle C Last CLARK
4. DATE OF DEATH Month DECEMBER Day 14 Year 1959
5. SEX Female
6. COLOR OR RACE W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Nov. 14, ~~1869~~ 1871
9. AGE (In years last birthday) 88 ~~90~~ yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Thomas Clagett
14. MOTHER'S MAIDEN NAME Elizabeth Eicher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Elizabeth Clark Address -5424 Neb Ave Wash. D.C

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA 420.0
DUE TO
(b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(c) GENERALIZED ARTERIOSCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
SENILITY
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from DEC. 7, 1959, to DEC. 14, 1959, that I last saw the deceased alive on DEC. 14, 1959, and that death occurred at 10:55 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Henryan Fowler M.D. ADDRESS (Street, city or town, state) 5206 Norway Dr. DATE SIGNED 12/14/59
PHYSICIAN'S NAME (Type) Cherry Chase, Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF 12-17-59
22c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium
22d. LOCATION (City, town, or county) (State) Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE J W Tyler ADDRESS Wash. D.C
24a. REC'D BY REGISTRAR DATE DEC 16 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be ret[illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13857 13823

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 607 Blandford Ave - apt 3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Rockville
d. STREET ADDRESS: 607 Blandford Ave - apt 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willis — Middle: Covert — Last: Clem
4. DATE OF DEATH: Month: Dec — Day: 14 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-5-1913
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Air Conditioning
10b. KIND OF BUSINESS OR INDUSTRY: N. I. H.
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Addison E. Clem
14. MOTHER'S MAIDEN NAME: Annie Lloyd
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Virginia Clem (wife) — Address: Clem 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-14-59
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 12/16/59
22c. NAME OF CEMETERY OR CREMATORY: Sunset
22d. LOCATION (City, town, or county) (State): Christiansburg, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home
ADDRESS: 1331 E. Montg. Ave., Rockville, Md.
24a. REC'D BY REGISTRAR: DATE DEC 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13883

Reg. Dist. No. 13824

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 42 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X WHEATON
d. STREET ADDRESS: 12004 CENTER HILL STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY Middle: LOUISE Last: Collins
4. DATE OF DEATH: Month: 12 Day: 5 Year: 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-2-1922
9. AGE (In years last birthday): 37 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOMEMAKER
11. BIRTHPLACE (State or foreign country): DISTRICT OF Columbia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ALBERT E. PRESTELE
14. MOTHER'S MAIDEN NAME: MARY ADALADE NASH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
INFORMANT: MR. FRANCIS Collins Address: SAME AS ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF OVARY — INTERVAL BETWEEN ONSET AND DEATH: APPROX. 8 WKS.
175.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ABOUT OCT. 15 1959, to DEC. 5, 1959, that I last saw the deceased alive on DEC. 5, 1959, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Tuohy M.D. ADDRESS (Street, city or town, state): 7720 Wisconsin Ave Bethesda 14 Md. DATE SIGNED: 12/5/59
PHYSICIAN'S NAME (Type): JOHN H. TUOHY 7720 WISCONSIN AVE. BETHESDA, 14, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-9-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE: Francis Hoffman ADDRESS: 3821-14th St. N.W., Wash. D.C.
24a. REC'D BY REGISTRAR DATE: DEC 7 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

HOSP. COPY

Reg. Dist. No. 13825

13884

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 12 hrs. 45 mins. X
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4810 Leland Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joh n Middle: A. Last: Corbin
4. DATE OF DEATH: Month: Dec. Day: 11 Year: 19 59
5. SEX: M ale
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/2/96
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Gov't
11. BIRTHPLACE (State or foreign country): Chicago, Ill
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Francis Corbin
14. MOTHER'S MAIDEN NAME: Mary Gallagher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT: Wife Address: Same as Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ruptured aneurysm Lt. Int cerebral artery — INTERVAL BETWEEN ONSET AND DEATH: 11 days
9040
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fell at home 10-31-59 and struck fractured on Concrete floor
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour 3 o. m. p. m. Month, Day, Year: 10-11 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Chevy Chase (County): Montg (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-11-59
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/14/59
22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
22d. LOCATION (City, town, or county) (State): Silver Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: DEC 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13885 Reg. Dist. No. 13826

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11731 College View Dr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 11731 College View Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: Robert Last: Corder
4. DATE OF DEATH: Month: Dec Day: 5 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-13-1917
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): D.C. Health Inspector
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Wilfred G. Corder
14. MOTHER'S MAIDEN NAME: Eliz. Fitzgerald
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 579-10-6987
17. INFORMANT: Margarite Corder (wife) Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-5-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-9-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE: Timothy Hanlon ADDRESS: 3831 Ga Ave NW
24a. REC'D BY REGISTRAR: DATE DEC 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13886

CERTIFICATE OF DEATH

13827

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 34 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10601 Nash Place

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 10601 Nash Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: JULIAN Middle: SMITH Last: COTTRELL

4. DATE OF DEATH: Month: Dec. Day: 1 Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 4, 1899
9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: Plumbing
11. BIRTHPLACE (State or foreign country): Richmond, Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Julian S. Cottrell
14. MOTHER'S MAIDEN NAME: Eva Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Evelyn C. Cottrell, (Same as #2) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Bronchus — INTERVAL BETWEEN ONSET AND DEATH: 1 Month
162.1
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/20/59 19____, to 12/1/59 19____, that I last saw the deceased alive on 12/1/59, 19____, and that death occurred at 5:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John J. Curry M.D. — ADDRESS (Street, city or town, state): 10620 Georgia Ave. Silver Spring, Md. — DATE SIGNED: 12/1/59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: Dec. 3, 1959
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town or county) (State): Prince George Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St NW DC
24a. REC'D BY REGISTRAR: DATE DEC 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG253 12-23-59 et

13887

CERTIFICATE OF DEATH

Reg. Dist. No. 13828

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 3 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8628 PINEY BRANCH ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 5b SILVER SPRING, MARYLAND
d. STREET ADDRESS: 8628 PINEY BRANCH ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORA Middle MARY Last CRONIN

4. DATE OF DEATH: Month DECEMBER Day 11 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: CAUCASOID
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 27, 1882
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): IRELAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MICHAEL REARDON
14. MOTHER'S MAIDEN NAME: MARY FOLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: MISS MARGARET CRONIN Address: 8628 PINEY BRANCH RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE — INTERVAL BETWEEN ONSET AND DEATH: 4 HOURS
462.1
DUE TO
(b) HEMORRHAGE — 6 HOURS
DUE TO
(c) ESOPHAGEAL VARICES — UNKNOWN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): HEPATIC CIRRHOSIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JULY 1955 to DEC. 11 1959 that I last saw the deceased alive on DEC. 11 1959, and that death occurred at 6:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph D. Connor M.D. — ADDRESS (Street, city or town, state): 9420 OLD GEORGETOWN RD. — DATE SIGNED: DEC 11, 1959

PHYSICIAN'S NAME (Type): JOSEPH D. CONNOR M.D. BETHESDA 14, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/15/59
22c. NAME OF CEMETERY OR CREMATORY: St Mary's Church
22d. LOCATION (City, town, or county) (State): Glen Echo Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Humphreys & Son
ADDRESS: 5732 Ga. Ave. N.W.
24a. REC'D BY REGISTRAR DATE: DEC 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13829

~~13888~~

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5835 Conway Road

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5835 Conway Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence Middle: A Last: Crowe
4. DATE OF DEATH: Month: Dec. Day: 8 Year: 19 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 16, 1908
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months 6 Days 12 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Military Planning
10b. KIND OF BUSINESS OR INDUSTRY: Officer USA
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: George Crowe
14. MOTHER'S MAIDEN NAME: Louella Reep
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 555-40-8479
17. INFORMANT: Irene Crowe-wife-same as 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Found dead
420.1
DUE TO (b): — in bed
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12/8/59
EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-11-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: DEC 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [illegible]. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13889 **CERTIFICATE OF DEATH** Reg. Dist. No. 13831

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY COUNTY GENERAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X OLNEY
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MORCAS Middle REBECCA Last DAVIS
4. DATE OF DEATH: Month DECEMBER Day 25 Year 19 59
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 2 1885
9. AGE (In years lost birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWF
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: -- Hiram Nesselrodt
14. MOTHER'S MAIDEN NAME: REBECCA K. --
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
INFORMANT: HOSPITAL RECORDS Address: OLNEY, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
443X
IMMEDIATE CAUSE (a) Asphyxia, hemorrhagica — 2 days
DUE TO
(b) Hypertensive cardiovascular disease — 10 yrs
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Oct, 1955, to Dec, 1959, that I last saw the deceased alive on Dec 25, 1959, and that death occurred at 5:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bonifant M.D. ADDRESS (Street, city or town, state): Sandy Spring Md DATE SIGNED: 12/26/59
PHYSICIAN'S NAME (Type): A. D. BONIFANT, M. D. SANDY SPRING, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 28 59
22c. NAME OF CEMETERY OR CREMATORY: Flower Hill
22d. LOCATION (City, town, or county) (State): Redland Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber ADDRESS: Laytonsville, Md.
24a. REC'D BY REGISTRAR DATE: DEC 31 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

VS A15 (4)
15M 9/58

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M

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13890

CERTIFICATE OF DEATH

13832

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 3 mo 5 da
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brooke Grove Foundation

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Howard ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Friendship 13t-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First: James — Middle: Edward — Last: Day

4. DATE OF DEATH: Month: Dec — Day: 5 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: March 29 1875

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months: ___ Days: ___ IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: James Day

14. MOTHER'S MAIDEN NAME: Martha Parsley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mary Mullinix — Address: West Friendship Howard Co. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
690.7
DUE TO (b): Fuxumenlosis — 1 wk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hemiplegia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/4, 19__, to 12/5, 1959, that I last saw the deceased alive on 12/5, 1959, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: C. H. Higginbotham M.D. — ADDRESS (Street, city or town, state): Sandy Spring — DATE SIGNED: 12/6/59

PHYSICIAN'S NAME (Type): C. H. Higginbotham MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-8-59

22c. NAME OF CEMETERY OR CREMATORY: Mt. View

22d. LOCATION (City, town, or county) (State): Alpha, Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F.C. Higinbothom, Ellicott City, Md

24a. REC'D BY REGISTRAR — DATE: DEC 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13891

CERTIFICATE OF DEATH

Reg. Dist. No. 13833

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda

c. LENGTH OF STAY IN 1b 9 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4840 Bayard Blvd.

d. STREET ADDRESS 4840 Bayard Blvd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LAURA Middle MAE Last DECKER

4. DATE OF DEATH Month December Day 22, Year 1959

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH January 28, 1889

9. AGE (In years last birthday) 70 yrs.

IF UNDER 1 YEAR Months 10 Days 24 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.

11. BIRTHPLACE (State or foreign country) Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James B. Burch

14. MOTHER'S MAIDEN NAME Lillian Colton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Address Mrs. Harold Ham-Item #2- Daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH less than hour

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis — years

DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 28, 1950, to present, 19____, that I last saw the deceased alive on Dec. 22, 1959, and that death accurred at 3:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE C. P. Ryland M.D. ADDRESS (Street, city or town, state) 4400 - 49th St. N.W Washington 16, D.C. DATE SIGNED 12-22-59

PHYSICIAN'S NAME (Type) C.P.RYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 12-24-59

22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State) Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey, Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE DEC 28 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13892

Reg. Dist. No. 13834

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 12,502 FELDON STREET

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING
d. STREET ADDRESS: 12,502 FELDON STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALZIRE Middle (nmi) Last DEMERS
4. DATE OF DEATH: Month DECEMBER Day 1 Year 19 59
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MARCH 10, 1887
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STAPLER (retired) PAPER
10b. KIND OF BUSINESS OR INDUSTRY: BOX MANUFACTURING
11. BIRTHPLACE (State or foreign country): CANADA
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: FABIEN LEGER
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 062-20-9085
17. INFORMANT: Mrs. Robert F. Snow, Address: 12,502 Feldon St., Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: (FOUND DEAD IN BED)
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: DEC. 1, 1959
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. & BURIAL
22b. DATE THEREOF: 12/5/59
22c. NAME OF CEMETERY OR CREMATORY: PARISH CEMETERY
22d. LOCATION (City, town, or county) (State): OGDENSBURG, NEW YORK

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Zuka
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE DEC 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13835

13893

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 75 Hammond Dr.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Clarksburg
d. STREET ADDRESS: 75 Hammond Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jimmie — Middle: Lee — Last: Derry
4. DATE OF DEATH: Month: Dec — Day: 5 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-11-59
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: — Days: 24
IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jimmie C. Derry
14. MOTHER'S MAIDEN NAME: Rosella Lee McCauley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rosella Derry — Address: Itma

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed
DUE TO
475 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Infected Respiratory Infection — 3 days
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

2

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-5-59
EXAMINER'S NAME (Type): FRANK J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 7 1959
22c. NAME OF CEMETERY OR CREMATORY: Laytonsville
22d. LOCATION (City, town, or county) (State): Laytonsville Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber — ADDRESS: Laytonsville, Md
24a. REC'D BY REGISTRAR: DATE DEC 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

2073326X04

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13894

CERTIFICATE OF DEATH

Reg. Dist. No. 13836

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 Days 8½ hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 7809 Boston Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mae — Middle: T. — Last: Edwards

4. DATE OF DEATH: Month: Dec — Day: 30 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11-19-87

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk (retired)

10b. KIND OF BUSINESS OR INDUSTRY: Newspaper

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Leonard Edwards

14. MOTHER'S MAIDEN NAME: Myra Travis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: yes

17. INFORMANT: Mrs. Wm. T. Lackland, 7809 Boston Ave. Silver Spring, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2-3 yrs
401.3
DUE TO
(b) Rheumatic fever — ?
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19 59, to 30 Dec, 19 59, that I last saw the deceased alive on 30 Dec 59, 19____, and that death occurred at 11:20 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William D Aud — M.D. — ADDRESS (Street, city or town, state): 9006 Colesville Rd Silver Spring Md — DATE SIGNED: 12/30/59

PHYSICIAN'S NAME (Type): WILLIAM D. AUD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1/2/60

22c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY

22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Ziska — ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE JAN 5 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13895 53

CERTIFICATE OF DEATH

Reg. Dist. No. 13837

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 6yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2102 Dexter Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 2102 Dexter Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Ann; Last: Eslin

4. DATE OF DEATH: Month: Dec; Day: 27; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: March 26 1869

9. AGE (In years lost birthday): 90 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Michael J McMahon

14. MOTHER'S MAIDEN NAME: Catherine Sullivan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr Henry C Eslin — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
4341
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Vascular Accident

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1955, to Dec 27, 1959, that I last saw the deceased alive on Dec 27, 1959, and that death occurred at 7:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John Lawrence Avery M.D. — ADDRESS (Street, city or town, state): 10110 Georgia Ave — DATE SIGNED: 12/27/59

PHYSICIAN'S NAME (Type): John Lawrence Avery — Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Dec. 30, 1959

22c. NAME OF CEMETERY ~~OR CREMATORY~~: St John's Church

22d. LOCATION (City, town, or county) (State): Forest Glen MD

23. FUNERAL DIRECTOR'S SIGNATURE: W W. Tattavull — ADDRESS: 3603 14th ST NW Wash DC

24a. REC'D BY REGISTRAR DATE: DEC 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13838

13896

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 181 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 5510 Hoover Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dean; Middle: (n); Last: FARNSWORTH

4. DATE OF DEATH: Month: December; Day: 27; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-22-02

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Elmer Farnsworth

14. MOTHER'S MAIDEN NAME: Angiline Small

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.:

INFORMANT: (Wife) Ruth B. Farnsworth
Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
147X
DUE TO
(b) CARCINOMA HYPOPHARYNX — 2 YEARS
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 29 June, 1959, to 27 December, 1959, that I last saw the deceased alive on 27 December, 1959, and that death occurred at 12:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George W. Taylor Jr. M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 12-28-59

PHYSICIAN'S NAME (Type): G.W. TAYLOR CDR MC USN — U.S. Naval Hospital, Bethesda Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 12-28-59

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory

22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co. — ADDRESS: 1400 Chapin St NW — W.W. Chambers 1400 Chapin Street N.W. Washington

24a. REC'D BY REGISTRAR — DATE: DEC 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re[illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1 X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG254 1-13-60 et

13897

13839

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83X-3
d. STREET ADDRESS: 626 South Stafford St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Leigh — Last: FASER

4. DATE OF DEATH: Month: December — Day: 23, ~~22~~ — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-21-59

9. AGE (In years lost birthday) yrs.: IF UNDER 1 YEAR: Months: Days: 2 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Karl E. Faser

14. MOTHER'S MAIDEN NAME: Mary Elizabeth SHANAHAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

INFORMANT: (Father) Karl E. Faser — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock and collapse — INTERVAL BETWEEN ONSET AND DEATH: 2 hr.
DUE TO
(b) Septicemia in the newborn — 1 day
DUE TO
(c) Probably caused by maternal bacteremia — 2 days

768.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 December, 1959 to 23 December, 1959 that I last saw the deceased alive on 23 December, 1959, and that death occurred at 3:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: GB Avery M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda Md. — DATE SIGNED: 12-23-59

PHYSICIAN'S NAME (Type): G.B.Avery LT MC USN — U.S. Naval Hospital, Bethesda Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-24-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE: R.A. Pumphrey — ADDRESS: R.A. Pumphrey 7557 Wisconsin, Ave. Bethesda Md.

24a. REC'D BY REGISTRAR — DATE: DEC 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

2051353XU4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13840

13898

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 3 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8606 Barron st.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 8606 Barron st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: — Last: Federman

4. DATE OF DEATH: Month: Dec — Day: 6 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11-26-1890

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Stationery Supplies

11. BIRTHPLACE (State or foreign country): N.Y.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob Federman

14. MOTHER'S MAIDEN NAME: Rachael Federman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 072-10-0076

17. INFORMANT: Pauline Federman (wife) — Address: Item 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-6-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/8-1959
22c. NAME OF CEMETERY OR CREMATORY: Mt Hope
22d. LOCATION (City, town, or county) (State): Hastings on the Hudson N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Goldberg Funeral Home Wash. D.C.

24a. REC'D BY REGISTRAR DATE: DEC 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your [illegible]
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13841

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 710 Boundry Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha; Middle: Emily; Last: Field

4. DATE OF DEATH: Month: 12; Day: 24; Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-8-58

9. AGE (In years last birthday): 1 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Wash. D.C.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Lawrence I Field

14. MOTHER'S MAIDEN NAME: Ruth Bisen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Mother — Address: 710 BOUNDRY AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Upper Respiratory Infection — 2 days
DUE TO (c):

475X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12-24-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/27/59

22c. NAME OF CEMETERY OR CREMATORY: NAT'L. MEM. PARK

22d. LOCATION (City, town, or county) (State): FALLS CHURCH, VA

23. FUNERAL DIRECTOR'S SIGNATURE: Goetting Funeral Home — ADDRESS: 4217-9th NW

24a. REC'D BY REGISTRAR: DATE DEC 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13842

13899 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3614 Sheppard St.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 3614 Sheppard St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Also known as First Frederick Middle Wm. Spletstoser Last Frederick William Fischer
4. DATE OF DEATH: Month Dec Day 31 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-28-1895
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales-Representative
10b. KIND OF BUSINESS OR INDUSTRY: Consultant Self-employed
11. BIRTHPLACE (State or foreign country): Mich.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frederick Wm. Spletstoser ~~Fischer~~
14. MOTHER'S MAIDEN NAME: Elizabeth Fischer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW #1
16. SOCIAL SECURITY NO.:
17. INFORMANT: Alice Fisher (wife) Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Braschart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED: 12-31-59
EXAMINER'S NAME (Type): FRANK J. Braschart

22a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. & BURIAL
22b. DATE THEREOF: 1/5/60
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): Jackson, Michigan
23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD. Raymond A. Zicka
24a. REC'D BY REGISTRAR DATE JAN 5 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13900

CERTIFICATE OF DEATH

Reg. Dist. No. 13843

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Gaithersburg
d. STREET ADDRESS: 300 N. Frederick Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lenganore; Middle: A.; Last: Fitzsimmons

4. DATE OF DEATH: Month: Dec.; Day: 8; Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/16/76
9. AGE (In years lost birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lenganore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William F. Boland
14. MOTHER'S MAIDEN NAME: Emma G. Poole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Yes
INFORMANT: Mrs. H.H. Ramsdell, Address: 3690 - 38th. St., N. W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cirhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: unknown
581.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Cardiovascular renal disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-29, 1959, to 12-8, 1959, that I last saw the deceased alive on 12-8-59, 19, and that death occurred at 7:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Morris Perry M.D. ADDRESS (Street, city or town, state): 11602 Georgia Ave Silver Spring Md. DATE SIGNED: 12-8-59
PHYSICIAN'S NAME (Type): Morris Perry

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/10/59
22c. NAME OF CEMETERY OR CREMATORY: St. Rose Cemetery
22d. LOCATION (City, town, or county) (State): Gaithersburg, R.F.D. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Gaithersburg, Md.
24a. REC'D BY REGISTRAR DATE: DEC 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be r[redacted]ed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13901 Reg. Dist. No. 13844

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 4319 Reno Rd. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

074

3. NAME OF DECEASED (Type or print): First: Charles Middle: O. Last: Fowler

4. DATE OF DEATH: Month: Dec. Day: 3 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3/19/86

9. AGE (In years lost birthday): 73 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Lawyer

11. BIRTHPLACE (State or foreign country): VILLA GROVE, ILL

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James M. Fowler

14. MOTHER'S MAIDEN NAME: Laura Overman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT: (Wife) Address: Same as Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 48-72 hrs
332X
DUE TO (b) Cerebral Vascular Occlusion — 7 Years
DUE TO (c) Hypertension - Arteriosclerosis Generalized

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to 12-3, 1959, that I last saw the deceased alive on Dec. 3, 1959, and that death occurred at 8:38 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE P. P. Andrews M.D. — **ADDRESS** (Street, city or town, state): 4201 Essenden St NW Washington D.C. — **DATE SIGNED**: 12-3-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/7/59

22c. NAME OF CEMETERY OR CREMATORY: Greenwood Cem.

22d. LOCATION (City, town, or county) (State): Michigan City, Ind

23. FUNERAL DIRECTOR'S SIGNATURE: Cheney Chapel Home — James Betts — **ADDRESS**: Wisc. Ave. N.W.

24a. REC'D BY REGISTRAR DATE: DEC 7 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13902

Reg. Dist. No. 13845

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney
c. LENGTH OF STAY IN 1b 1/2 hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Medical Center, Sandy Spring, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Dorothy Middle Wyckoff Last Fraley
4. DATE OF DEATH Month 12 Day 29 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1.11.96
9. AGE (In years lost birthday) 63 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME James Kinney
14. MOTHER'S MAIDEN NAME Violet Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Hospital Records, Olney, Maryland Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 1/2 hr
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/ 19 57, to 12.29.59, 19__, that I last saw the deceased alive on 12.29.59, 19__, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE C. H. Ligon M.D. ADDRESS (Street, city or town, state) Medical Center, Sandy Spring, Md. DATE SIGNED

PHYSICIAN'S NAME (Type) C. H. Ligon, M. D., Medical Center, Sandy Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1-1-60
22c. NAME OF CEMETERY OR CREMATORY St. Luke's Lutheran
22d. LOCATION (City, town, or county) (State) Redland, Mont. Md.

23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber ADDRESS Laytonsville, Md.
24a. REC'D BY REGISTRAR DATE JAN 4 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13903

CERTIFICATE OF DEATH

Reg. Dist. No. 13849

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

074

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1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 1 day 17 hrs. 15 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING
d. STREET ADDRESS: 4400 SIGSBEE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAUL A. FRANCESCO; Middle; Last
4. DATE OF DEATH: Month DECEMBER; Day 24; Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 22, 1959
9. AGE (In years last birthday): 0 yrs. — IF UNDER 1 YEAR: Months 0, Days 1; IF UNDER 24 HRS.: Hours 17, Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: DOMINICK L. FRANCESCO
14. MOTHER'S MAIDEN NAME: HELEN PATRICIA SCHUTZLER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
INFORMANT: MRS. EVELYN TAUBER, 123 TALBOTT ST., ROCKVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): multiple congenital anomalies 1) meningocoele 2) central nervous system defects.
753.1
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Dec 22, 1959 to Dec 24, 1959 that I last saw the deceased alive on Dec 24, 1959 and that death occurred at 4 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Patrick C. Jameson M.D. — ADDRESS (Street, city or town, state): 12070 Georgia Silver Spring, Md. — DATE SIGNED: 12/25/59

PHYSICIAN'S NAME (Type): PATRICK C. JAMESON

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: DEC. 26, 1959
22c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc., Silver Spring, Md. — ADDRESS: Raymond A. Zeska
24a. REC'D BY REGISTRAR — DATE: DEC 28 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A1S (4)
15M 9/58

2074 313XU4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13846

Reg. Dist. No. ~~13906~~

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brooke Grove foundation

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 4819 Illinois ave N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

090

3. NAME OF DECEASED (Type or print): First: Rose Middle: Friedman Last:
4. DATE OF DEATH: Month: Dec Day: 5 Year: 1959
5. SEX: F
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 14 1884
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Houseduties
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hungary
12. CITIZEN OF WHAT COUNTRY: US
13. FATHER'S NAME: Hyman Friedman
14. MOTHER'S MAIDEN NAME: Hanna Greenfeld
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None —
17. INFORMANT: Albert Rathner Address: 6417 Kansas Ave NE DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
350X
DUE TO
(b): Parkinsonism — 4 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/12, 1959, to 12/5, 1959, that I last saw the deceased alive on 12/4, 1959, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. H. Ligon M.D. ADDRESS (Street, city or town, state): Sandy Spring, Md. DATE SIGNED: 12/5/59

PHYSICIAN'S NAME (Type): C. H. Ligon.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/6-1959
22c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
22d. LOCATION (City, town, or county) (State): Falls Church Va

23. FUNERAL DIRECTOR'S SIGNATURE: Goldberg Funeral Home ADDRESS: Wash. DC
24a. REC'D BY REGISTRAR DATE: DEC 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13905 — Reg. Dist. No. 13847

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 10 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2238 Washington Ave - Apt 102

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 2238 Washington Ave Apt 102
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Franklin — Middle: Harrison — Last: Funk

4. DATE OF DEATH: Month: Dec — Day: 14 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 1-10-1917
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper
10b. KIND OF BUSINESS OR INDUSTRY: P.O. Dept
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles A. Funk
14. MOTHER'S MAIDEN NAME: Alice Tumney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 171-09-2223
17. INFORMANT: Elaine Funk (wife) — Address: Silver

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 12-15-59
EXAMINER'S NAME (Type): FRANK J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. & BURIAL
22b. DATE THEREOF: 12/16/59
22c. NAME OF CEMETERY OR CREMATORY: HILLSIDE CEMETERY
22d. LOCATION (City, town, or county) (State): FULLERTON, LEHIGH COUNTY, PA.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. — Raymond A. Zeska
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: DEC 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13906

CERTIFICATE OF DEATH

Reg. Dist. No. 13848

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY: 47X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wash. 16 D.C.
d. STREET ADDRESS: 5016 45th N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M

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3. NAME OF DECEASED (Type or print): First: China — Middle: Clay — Last: Furr

4. DATE OF DEATH: Month: 12 — Day: 26 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar 15 1885

9. AGE (In years lost birthday): 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

I

13. FATHER'S NAME: Wilson ?

14. MOTHER'S MAIDEN NAME: Nicely ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 579-09-604

INFORMANT: Florence C. Furr — Address: 5016 45th N.W. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

443X

DUE TO (b): Acute Congestive Heart Failure — 48 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypertension Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 12-26, 1959, to 12-26, 1959, that I last saw the deceased alive on 12-26, 1959, and that death occurred at 8:37 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: P. P. Andrews M.D. — ADDRESS (Street, city or town, state): 4201 Fessenden St N.W. — DATE SIGNED: 12-26-1959

PHYSICIAN'S NAME (Type): P. P. ANDREWS M.D. Washington D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-29-59

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: DEAL FUNERAL HOME 4812 Ga Ave

24a. REC'D BY REGISTRAR — DATE: JAN 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13907

CERTIFICATE OF DEATH

Reg. Dist. No. 13850

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Bethesda, Md.
c. LENGTH OF STAY IN 1b: 88 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Naval Hospital, NNMC, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Washington, D.C.
b. COUNTY: Thomas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. (16)
d. STREET ADDRESS: 5215 Massachusetts Ave. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Leslie — Middle Tracy — Last GAGER

4. DATE OF DEATH: Month December — Day 25 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 27 1890

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Medical Doctor

10b. KIND OF BUSINESS OR INDUSTRY: Medical

11. BIRTHPLACE (State or foreign country): Connecticut

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: John A. Gager

14. MOTHER'S MAIDEN NAME: Luella Tracy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1st & 2nd W.W.

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Josephine C. Gager — Address: 5215 Mass Ave, W.D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia (Organism Unknown) — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b) Pemphigus Foliaceus — 3 months
DUE TO
(c)

704.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from September 28, 1959, to December 25, 1959, that I last saw the deceased alive on December 25, 1959, and that death occurred at 2:53 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: James M. Young M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda Md. — DATE SIGNED: 12-26-59

PHYSICIAN'S NAME (Type): James M. YOUNG LT MC USN — U.S.Naval Hospital, Bethesda, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-28-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. De Vol — ADDRESS: De Vol Funeral Home 2224 Wisconsin Ave., W.DC.

24a. REC'D BY REGISTRAR — DATE DEC 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13833

CERTIFICATE OF DEATH

Reg. Dist. No. 13851

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium + Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 525 Silver Spring
d. STREET ADDRESS: 12905 Bluhill Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

075

3. NAME OF DECEASED (Type or print): First: Bertha Middle: (NMN) Last: Garfinkel
4. DATE OF DEATH: Month: 12 Day: 16 Year: 1959
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-15-86
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife.
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Kontorsky
14. MOTHER'S MAIDEN NAME: Libby
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): None (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
INFORMANT: Son. Address: SAME AS ABOVE

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction due to coronary occlusion (left anterior descending branch) — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
420.0
DUE TO (b) Arteriosclerotic heart disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 12-14, 1959, to 12-16, 1959 that I last saw the deceased alive on 12-16, 1959, and that death occurred at 9:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John Harper M.D. ADDRESS (Street, city or town, state): 931 Pershing Drive, Silver Spring, Md. DATE SIGNED: 12-16-59

PHYSICIAN'S NAME (Type)

1

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/17/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cem.
22d. LOCATION (City, town, or county) (State): Brooklyn. N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: Goldberg Funeral Home ADDRESS: 4217 9th NW DC
24a. REC'D BY REGISTRAR DATE: DEC 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,4,11 FilmG254 12-30-59 et

13834

CERTIFICATE OF DEATH

GARFITT

Reg. Dist. No. 13852

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 36 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San + Hosp.

075

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ~~Maryland~~ N. C.
b. COUNTY: ~~Montgomery~~ Orange County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Bethesda~~ Chapel Hill 70 x 3
d. STREET ADDRESS: ~~5357 Rockhill Rd.~~ # 1 Brandon Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Barbara; Middle: Wighton; Last: Garfitt
4. DATE OF DEATH: Month: 12; Day: 9; Year: 1959
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 7 - 1884
9. AGE (In years lost birthday): 75 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): ~~Scotland~~ Nebraska
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Donald McGuire
14. MOTHER'S MAIDEN NAME: Jane Doctor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Daughter: Mrs. Arthur Roe — Address: 5357 Rockhill Rd. - Bethesda Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
578X
DUE TO (b) Renal Shutdown — 2 wks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Congestive Heart failure due to Hypoproteinemia,

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): due to Malabsorption Syndrome Secondary to Gastroenterostomy

0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 3, 1959 to December 9, 1959 that I last saw the deceased alive on December 9, 1959, and that death occurred at 3:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward Lewis Jr. M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED
PHYSICIAN'S NAME (Type): EDWARD LEWIS, JR., 5800 BEECH AVE., BETHESDA, MD

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 14. 1959
22c. NAME OF CEMETERY OR CREMATORY: Wymore Cemetery
22d. LOCATION (City, town, or county) (State): Wymore, Nebraska
23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters, ADDRESS: 254 Carroll St NW DC.
24a. REC'D BY REGISTRAR: DATE DEC 11 '59
24b. REGISTRAR'S SIGNATURE: Cathrine S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13853

Reg. Dist. No. 13908

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: 18 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7104 Delaware St

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE: Md b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 7104 Delaware St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Joseph Middle: A. Last: Gargiulo Jr.
4. DATE OF DEATH Month: Dec Day: 10 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-9-1884
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months 2 Days 1 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trust Officer
10b. KIND OF BUSINESS OR INDUSTRY: Nat. Saving & Trust Co
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph A. Gargiulo
14. MOTHER'S MAIDEN NAME: Margaretta Myer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-03-4517
17. INFORMANT: Clara Hurley Address: 8516 Beach Tree Rd Bethesda

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage + laceration — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b) Gun shot wound -

DUE TO (c) Head partially decapitated

976X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Reported to have been ill with C.A. of prostate with metastasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Buschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-10-59
EXAMINER'S NAME (Type): FRANK J. Buschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 12-12-59
22c. NAME OF CEMETERY OR CREMATORY: Kensico Cemetery
22d. LOCATION (City, town, or county) (State): Valhalla, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Son, Inc. ADDRESS: 1756 Pa. Ave. N.W. Washington, D. C.
24a. REC'D BY REGISTRAR DATE: DEC 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13909

Reg. Dist. No. 13854

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 509 Copley Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie; Middle: May; Last: Gooding

4. DATE OF DEATH: Month: 12; Day: 27; Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8/11/99

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Rufus King

14. MOTHER'S MAIDEN NAME: — unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

INFORMANT: Edward T. Gooding, 509 Copley Lane — Address: Silver Spring Md.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b) Thrombophlebitis, left leg — 8 days
DUE TO (c)

463X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to Dec 27, 1959, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:45 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE James H Scally **M.D.** — **ADDRESS** (Street, city or town, state): 1835 Eye St NW — **DATE SIGNED**

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-31-59

22c. NAME OF CEMETERY OR CREMATORY: Mount Olivet

22d. LOCATION (City, town, or county) (State): Frederick Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. W. Lee — **ADDRESS**: Wash. D.C.

24a. REC'D BY REGISTRAR DATE DEC 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13855

1. PLACE OF DEATH 13858
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): #2 Alsace Lane

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Rockville
d. STREET ADDRESS: #2 Alsace Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis Middle: S. Last: Gospodarek
4. DATE OF DEATH: Month: Dec. Day: 8 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 5, 1959
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 2 Days: 3
IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Francis S. Gospodarek
14. MOTHER'S MAIDEN NAME: Mary P. Brosnan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Francis S. Gospodarek-father-same as 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
475X
DUE TO (b): Upper respiratory infection
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Frank J. Broschart
DATE SIGNED: 12/8/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/10/59
22c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE DEC 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

207428 4X04

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13910

Reg. Dist. No. 21 13856

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 71 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Florida
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Patrick Air Force Base 48X-3
d. STREET ADDRESS: 1031 D AlA
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

051

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Steffens — Last: GRAFF

4. DATE OF DEATH: Month: December — Day: 16 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 10-29-01
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (State or foreign country): Kentuckey
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Joseph H. GRAFF
14. MOTHER'S MAIDEN NAME: Helen L. STEFFENS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I and II
16. SOCIAL SECURITY NO.:
INFORMANT: (Wife) Mildred C. Graff — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with metastasis
DUE TO
(b)
DUE TO
(c)

162.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 October, 1959, to 16 December, 1959, that I last saw the deceased alive on 16 December, 1959, and that death occurred at 10:25AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Douglas R. Koth M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda Md. — DATE SIGNED: 12-16-59

PHYSICIAN'S NAME (Type): D.R. KOTH LCDR MC USN — U.S. Naval Hospital, Bethesda Md.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-18-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE: R. A. Pumphrey — **ADDRESS**: 7557 Wisconsin Ave. Bethesda Md.
24a. REC'D BY REGISTRAR — DATE: DEC 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG253 12-11-59 et

13835

CERTIFICATE OF DEATH

Reg. Dist. No. 13857

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4yrs 10mo 5days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY: ?
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Summit — 67X-3
d. STREET ADDRESS: Suburban Hotel
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

075

3. NAME OF DECEASED (Type or print): First E. Middle Norma P. Last Graham
4. DATE OF DEATH: Month 12 Day 5 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 10-8-85
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Not Known-by Hosp.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: Marcus Purcell
14. MOTHER'S MAIDEN NAME: Sarah Reeder
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: pt Chart of Wash San & Hosp. — Address

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 day
331X
DUE TO (b) Hypertension — ? years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Arteriosclerosis — ? years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1956 to 12-5, 1959 that I last saw the deceased alive on 12-5, 1959, and that death occurred at 5 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Hare M.D. — ADDRESS (Street, city or town, state): 7600 Carroll Ave., Tak. Park, Md. — DATE SIGNED: 12/5/59

PHYSICIAN'S NAME (Type): Robert A. Hare

22a. BURIAL, CREMATION, REMOVAL (Specify): removal
22b. DATE THEREOF: 12/9/59
22c. NAME OF CEMETERY OR CREMATORY: Jackson Memorial Cem.
22d. LOCATION (City, town, or county) (State): Lexington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: S.H. Hines Co — ADDRESS: 2901-14th St. N.W.
24a. REC'D BY REGISTRAR DATE DEC 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13911

CERTIFICATE OF DEATH

13858

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Monta.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Wheaton
d. STREET ADDRESS: 13502 Grenoble Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: NANCY Middle: JANE Last: GRANZOW
4. DATE OF DEATH: Month: 12 Day: 4 Year: 1959
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 18 1921
9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months: 6 Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Frank O. Shrodes
14. MOTHER'S MAIDEN NAME: Ethel McCarter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 579-18-7615
INFORMANT: Richard Granzow — Address: Husband Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
170X
DUE TO (b): Status Post Operation - Carcinoma Left Breast — 6 Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Radiation pneumonitis, left lung
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-11, 1958, to 12-4, 1959 that I last saw the deceased alive on 12-4, 1959, and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sarah E Glover M.D. ADDRESS (Street, city or town, state): 10128 Cedar Lane Kensington, Md DATE SIGNED: 12-5-59
PHYSICIAN'S NAME (Type): SARAH E GLOVER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/8/59
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Nalley's Funeral Home Inc. ADDRESS: Mt. Rainier Md.
24a. REC'D BY REGISTRAR DATE: DEC 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13912

CERTIFICATE OF DEATH

13859

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 7608 Clarendon Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth; Middle: Perry; Last: Griffith

4. DATE OF DEATH: Month: 12/10; Day; Year: 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/17/79
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months: 9; Days: 23; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard H. Perry
14. MOTHER'S MAIDEN NAME: ~~Waters~~ Margaret Waters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - - - - -
16. SOCIAL SECURITY NO.: None
INFORMANT: Mrs. J. H. Littlepage, 8612 Ridge Rd., Beth.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 5 days
331X
DUE TO
(b): cerebral arteriosclerosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c): X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchopneumonia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 5, 19 59 to Dec. 10 19 59, that I last saw the deceased alive on Dec. 10 19 59, and that death occurred at 2:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: George A. Gray, Jr. M.D. — ADDRESS (Street, city or town, state): 4422 East West Hwy, — DATE SIGNED: 12/16/59

PHYSICIAN'S NAME (Type): George A. Gray, Jr. M.D. Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-12-59
22c. NAME OF CEMETERY OR CREMATORY: Monocacy Cemetery
22d. LOCATION (City, town, or county) (State): Beallsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: DEC 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13836

CERTIFICATE OF DEATH

13860

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK, MARYLAND
c. LENGTH OF STAY IN 1b: 4 mo 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 700-HUDSON AVENUE-EVENTIDE NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA — b. COUNTY: 47x3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, DISTRICT OF COLUMBIA
d. STREET ADDRESS: 615-UNDERWOOD STREET, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DORA — Middle M. — Last HAACK
4. DATE OF DEATH: Month DECEMBER — Day 19th — Year 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: APRIL 30, 1878
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months 7, Days 19 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE - AT HOME
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: August Brasa
14. MOTHER'S MAIDEN NAME: Doris Eberhardt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: MR. FRED J. HAACK (SON) — Address: WASHINGTON, D.C. 615-UNDERWOOD ST, N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min
420.1
DUE TO
(b) Arteriosclerotic cardiovascular — 7 yrs
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 1, 1952, to Dec 19, 1959, that I last saw the deceased alive on Dec 8, 1959, and that death occurred at 11:50 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M.F. Ottman M.D. — ADDRESS (Street, city or town, state): 401 Kennedy St NW Washington DC — DATE SIGNED: 12/20/59

PHYSICIAN'S NAME (Type): M.F. OTTMAN — 401-KENNEDY STREET, N.W.-WASH. D.C. 12/20/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12-22-59
22c. NAME OF CEMETERY OR CREMATORY: PROSPECT HILL
22d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: MARTIN W. HYSONG COMPANY — ADDRESS: 1309-N. ST, N.W.-WASHINGTON, D.C.
24a. REC'D BY REGISTRAR: DATE DEC 22 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13913

CERTIFICATE OF DEATH

Reg. Dist. No. 13861

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: 12 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4005 Underwood St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4005 Underwood St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dora Middle: Albaugh Last: Hale
4. DATE OF DEATH: Month: December Day: 27 Year: 1959
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 4, 1862
9. AGE (In years last birthday): 97 yrs. IF UNDER 1 YEAR: Months, Days IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): homemaker
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Benjamin Albaugh
14. MOTHER'S MAIDEN NAME: Priscilla Mendenhall
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unknown ~~none~~
17. INFORMANT: Mrs. Sarah Sutton Address: 4005 Underwood St. Chevy Chase, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.2 Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b) Chronic myocarditis — Over 30 yrs
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 21, 1947, to Dec. 27, 1959, that I last saw the deceased alive on Dec. 27, 1959, and that death occurred at 12:20 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Katharine A. Chapman M.D. ADDRESS (Street, city or town, state): 3924 Baltimore St. DATE SIGNED:
PHYSICIAN'S NAME (Type): Katharine A. Chapman, M.D. Kensington, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Trans. Bur.
22b. DATE THEREOF: 12/29/59
22c. NAME OF CEMETERY OR CREMATORY: West Milton Cemetery
22d. LOCATION (City, town, or county) (State): West Milton, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
24a. RECD. BY REGISTRAR DATE: DEC 30 59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13914

CERTIFICATE OF DEATH

Reg. Dist. No. 13862

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BETHESDA
d. STREET ADDRESS: 5919 ANNISTON ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILIAN Middle DEARY Last Hamilton

4. DATE OF DEATH: Month 12 Day 7 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 3-21-1901

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SECRETARY

10b. KIND OF BUSINESS OR INDUSTRY: BRITISH EMBASSY

11. BIRTHPLACE (State or foreign country): LONDON, ENGLAND

12. CITIZEN OF WHAT COUNTRY?: CANADA

13. FATHER'S NAME: HENRY DEARY ROSS

14. MOTHER'S MAIDEN NAME: LILLIAN CATHARINE GODFREY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

INFORMANT: (NIECE) SHIRLEY D. TANNER — Address: 5919 ANNISTON RD. BETHESDA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis, Metastatic to liver — INTERVAL BETWEEN ONSET AND DEATH: 3 months
153.0
DUE TO
(b) Carcinoma of Cecum — 3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1954, to December 7, 1959, that I last saw the deceased alive on December 7, 1959, and that death occurred at 11:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. Roger Kurtz M.D. — ADDRESS (Street, city or town, state): 3701 Conn Ave. NW — DATE SIGNED: 12-7-59

PHYSICIAN'S NAME (Type): C. Roger Kurtz M.D. Wash. 8, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit

22b. DATE THEREOF: 12/11/59

22c. NAME OF CEMETERY OR CREMATORY: Pine Hills Cemetery

22d. LOCATION (City, town, or county) (State): Toronto, Canada

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: DEC 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1 X

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13915 Item 7 Film G253 12-17-59 et

13863 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: MONTGOMERY MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda Naval Hosp

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bethesda Naval Hosp.

051

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4

d. STREET ADDRESS: 8 W. Jeffery Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eddie Middle: Roy Last: Harris

4. DATE OF DEATH Month: Dec. Day: 9 Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8/25/1907

9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months: 3 Days: 14 IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Harris

14. MOTHER'S MAIDEN NAME: Bessie Rogers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family Address: Same

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 0 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. p. m. Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9 Dec. 1959

EXAMINER'S NAME (Type): John G. Ball

2

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/13/59

22c. NAME OF CEMETERY OR CREMATORY: Oakwood Cem.

22d. LOCATION (City, town, or county) (State): Siler City, N.C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: McCully Funeral Homes 130 E. Fort Ave.

24a. REC'D BY REGISTRAR DATE: DEC 11 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13916

CERTIFICATE OF DEATH

Reg. Dist. No. 13864

M

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 27 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

050

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia b. COUNTY: Arlington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83 x 3

d. STREET ADDRESS: 4916 35th Street, North

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lawrence Middle: Stone Last: Haseltine

4. DATE OF DEATH Month: December Day: 1 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 23 July 1947

9. AGE (In years lost birthday): 12 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathan S. Haseltine

14. MOTHER'S MAIDEN NAME: Emily Clevenger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH

224X

DUE TO (b) Pheochromocytoma — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 4, 1959, to December 1, 1959 that I last saw the deceased alive on December 1, 1959, and that death occurred at 4:50 PM from the causes and on the date stated above.

ACTUAL SIGNATURE Louis Gillespie Jr. M.D. **ADDRESS** (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland **DATE SIGNED** 12/1/59

1

PHYSICIAN'S NAME (Type) Louis Gillespie Jr. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 12-4-59

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home By: C. M. Frame **ADDRESS** 2847 Wilson Blvd., Arlington, Va.

24a. REC'D BY REGISTRAR DATE DEC 7 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13917

Reg. Dist. No. 215 13865

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 319 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3133 Conn. Ave. Kennedy/Apt. Warren
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47 x-3

051

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Martha — Last: HECK

4. DATE OF DEATH: Month: December — Day: 6 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 3-25-94
9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

I

13. FATHER'S NAME: John HECK
14. MOTHER'S MAIDEN NAME: Sarah LOGUE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.:
INFORMANT: (Sister) Elsie H. Eleder — Address: 2201 Echodale Ave Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, breast c generalized metastasis — INTERVAL BETWEEN ONSET AND DEATH: 4 1/2 yrs.
170 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 January, 1959, to 6 December, 1959 that I last saw the deceased alive on 6 December, 1959, and that death occurred at 5:06 M, from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D. — **ADDRESS** (Street, city or town, state): U.S. Naval Hospital, Bethesda Md. — **DATE SIGNED**: 12-7-59

1

PHYSICIAN'S NAME (Type): D.P. ~~OSBORNE CAPT MC USN~~ — U.S. Naval Hospital, Bethesda Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-9-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawlers & Sons — **ADDRESS**: Joseph Gawlers 1756 Penn. Ave. N.W. Washington, D.C.
24a. REC'D BY REGISTRAR: DEC 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13918 — Reg. Dist. No. 13866

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8300 Tilbury Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 8300 Tilbury St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAROLD — Middle C. — Last HEIGHAM
4. DATE OF DEATH: Month Dec. — Day 3, — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 18, 1904
9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Draftsman
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William H. Heigham
14. MOTHER'S MAIDEN NAME: Ella A. Ittner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Wife — Address: Same as Item #2 — Sarah M. Heigham

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Dec. 3, 1959
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-5-59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery.
22d. LOCATION (City, town, or county) (State): Prince George Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR: DEC 7 '59 — DATE
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13867

13919

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney, Md.
c. LENGTH OF STAY IN 1b: 11½ hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montg. County Gen. Hosp. Inc.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring, Md.
d. STREET ADDRESS: 1307 Hornell Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herman Middle: August Last: Heine
4. DATE OF DEATH: Month: 12 Day: 18 Year: 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/20/87
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Govt. Clerk-retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Gotleib Heine
14. MOTHER'S MAIDEN NAME: Pauline Hoffman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
825X
DUE TO (b): Thoracic hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Crushed chest

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of car involved in auto accident
20c. TIME OF INJURY: Hour 2:52 XX p. m. Month, Day, Year 12, 17 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) (County) (State): Fulton Howard Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12/18/59
EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: Dec 21, 1959
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery Crematory
22d. LOCATION (City, town, or county) (State): Prince George Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St NW DC
24a. RECD BY REGISTRAR DATE: DEC 21 '59
24b. REGISTRAR'S SIGNATURE: Collins & Kane

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13920

CERTIFICATE OF DEATH

13868

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Althea Woodland Nursing Home 9301 Weaver Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DC
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 1661 Harvard Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Milton Middle: Lost: Herman
4. DATE OF DEATH: Month: Dec Day: 9 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/26/79
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Operator
10b. KIND OF BUSINESS OR INDUSTRY: Ladies Wear
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Abraham Herman
14. MOTHER'S MAIDEN NAME: Amelia Fishman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ---
INFORMANT: Home Records — Address: 9301 Weaver Street Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 day
331X
DUE TO (b): Hypertension — several years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Former Hemiplegia Oct 1958
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 1959, to Dec 9, 1959, that I last saw the deceased alive on Dec 8, 1959, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John N. Andrews M.D. ADDRESS (Street, city or town, state): 9601 Colesville Rd Silver Spring Md DATE SIGNED: Dec 9-59
PHYSICIAN'S NAME (Type): John N. Andrews

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 12/9/59
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR DATE: DEC 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13837

Reg. Dist. No. 13869

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 Takoma Park,
d. STREET ADDRESS: 8625 Piney Branch Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

075

3. NAME OF DECEASED (Type or print): First — Middle — Last: Hester

4. DATE OF DEATH: Month 12 Day 13 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12-13-59

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: America

13. FATHER'S NAME: Hester, William C.

14. MOTHER'S MAIDEN NAME: ~~Hester~~ Marian Louise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity - 23 wks. gestation — INTERVAL BETWEEN ONSET AND DEATH
776X
DUE TO
(b) Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9:25 AM, 1959, to 9:50 AM, 1959, that I last saw the deceased alive on 12-13, 1959, and that death occurred at 9:50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Emma Hughes M.D. ADDRESS (Street, city or town, state): Washington Sanitarium and Hospital DATE SIGNED

PHYSICIAN'S NAME (Type): Emma Hughes, M. D. Washington Sanitarium and Hospital

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 12-14-59

22c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital

22d. LOCATION (City, town, or county) (State): Takoma Park, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M. D.

ADDRESS: Washington Sanitarium and Hosp. Takoma Park, Md.

24a. REC'D BY REGISTRAR DATE: DEC 16 '59

24b. REGISTRAR'S SIGNATURE: Adams S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

21 75211 XVO

1 X

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13838

Reg. Dist. No. 13870

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN 1b: 51 Hrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring

d. STREET ADDRESS: 12127 Georgia Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

075

3. NAME OF DECEASED (Type or print): First: Helen Middle: Elizabeth Last: Hoback

4. DATE OF DEATH Month: 12 Day: 1 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3-22-12

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fountain Clerk

10b. KIND OF BUSINESS OR INDUSTRY: –

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry D. Spangler.

14. MOTHER'S MAIDEN NAME: Lottie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): –

16. SOCIAL SECURITY NO.: –

INFORMANT: Hospital Records Address:

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

331X

DUE TO (b): essential hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Cerebral hemmorhage

Pulmonary edema

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary edema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September, 1959, to Dec 1, 1959, that I last saw the deceased alive on Dec 1, 1959, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Patrick C Jameson M.D. ADDRESS (Street, city or town, state): 12020 Georgia DATE SIGNED: 12/1/59

PHYSICIAN'S NAME (Type): PATRICK C JAMESON Silver Spring, Md

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/5/59

22c. NAME OF CEMETERY OR CREMATORY: Green Hill

22d. LOCATION (City, town, or county) (State): Waynesboro Franklin Co., Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Y. Grove, Waynesboro Pa ADDRESS:

24a. REC'D BY REGISTRAR DATE: DEC 3 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13921

Reg. Dist. No. 13871

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LeDeau Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pro Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bradbury Park, Md. 16 X - 2
d. STREET ADDRESS: 4629 Davis avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First MINNIE Middle Last HOBBS
4. DATE OF DEATH: Month December Day 21 Year 1959
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: ?
9. AGE (In years last birthday): 80 ? yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Maybell Gall Address: Bradbury Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

786.5

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyper pyrexia, Unknown Cause — 36 hours

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1959 to Dec 20, 1959, that I last saw the deceased alive on Dec 20, 1959, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert T. Thibadeau M.D. ADDRESS (Street, city or town, state): 10609 Concord Street DATE SIGNED: Dec 21, 1959

PHYSICIAN'S NAME (Type): Robert T. Thibadeau, M.D. Kensington, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/23/59
22c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery
22d. LOCATION (City, town, or county) (State): Washington D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons ADDRESS: Hyattsville Md.
24a. REC'D BY REGISTRAR DATE: DEC 22 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13922

CERTIFICATE OF DEATH

13872
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9806 Forest Grove Drive

d. STREET ADDRESS: 9806 Forest Grove Drive

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Mattie Middle Lula Last Hodge

4. DATE OF DEATH: Month December Day 31 Year 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Dec 17, 1878

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Ivan Renfrow

14. MOTHER'S MAIDEN NAME: Cora Ann Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: No

INFORMANT: Alga Hodge Address: 1601 Argonne Pl NW- DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
450.0
DUE TO
(b) General Arteriosclerosis — 4-5 year.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-12, 1959, to 12-31, 1959, that I last saw the deceased alive on 12-30, 1959, and that death occurred at 10:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W B Wardrop M.D. ADDRESS (Street, city or town, state): 800 Pershing Drive Silver Spring DATE SIGNED: 12/31/59

PHYSICIAN'S NAME (Type): W.B. Wardrop

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 1/1/1960

22c. NAME OF CEMETERY OR CREMATORY: Maplewood

22d. LOCATION (City, town, or county) (State): Wilson, North Carolina

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: The S.H. Hines Co.-2901 14th St., N.W. Washington 9, D.C.

24a. REC'D BY REGISTRAR DATE JAN 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13873

Reg. Dist. No. 13923

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mont. Co. Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Holland 13x-2
d. STREET ADDRESS: Hall's Shop Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

099

3. NAME OF DECEASED (Type or print): First: Eli — Middle: Hottinger — Last:

4. DATE OF DEATH: Month: Dec — Day: 20 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 2-14-1891
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY: Landscape
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

I

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220 32 6658
17. INFORMANT: Beulah Hottinger — Address: Ilion 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr
421.4
DUE TO (b): Chronic Valvular heart disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-20-59

2

EXAMINER'S NAME (Type): FRANK J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 23 '59
22c. NAME OF CEMETERY OR CREMATORY: St. Lukes
22d. LOCATION (City, town, or county): Redland (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber
ADDRESS: Laytonsville, Md
24a. REC'D BY REGISTRAR DATE: DEC 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13924

CERTIFICATE OF DEATH

13874

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY COUNTY GENERAL HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X DERWOOD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

073

3. NAME OF DECEASED (Type or print): First FLORENCE Middle VIRGINIA Last HOTTINGER

4. DATE OF DEATH: Month DECEMBER Day 25 Year 19 59

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/2/ 1889
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWF
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

I

13. FATHER'S NAME: LEVI -Brady
14. MOTHER'S MAIDEN NAME: SUSAN -- Whitecotton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
INFORMANT: HOSPITAL RECORDS Address: OLNEY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis (Recurrent) — INTERVAL BETWEEN ONSET AND DEATH: 3 days
332X
DUE TO
(b) Arteriosclerosis, generalized, severe — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension, essential; Subacute urinary infection
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1955, to December 25, 1959, that I last saw the deceased alive on Dec 25, 1959, and that death occurred at 10:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Meadors M.D. M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 12/26/59

PHYSICIAN'S NAME (Type): G.F. MEADORS, M. D. DAMASCUS, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 29, 1959
22c. NAME OF CEMETERY OR CREMATORY: Flower Hill
22d. LOCATION (City, town, or county) (State): Redland, Mont., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber. ADDRESS: Laytonsville, Md.
24a. REC'D BY REGISTRAR DATE: DEC 31 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13839

CERTIFICATE OF DEATH

Reg. Dist. No. 13875

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Wash. D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47X-3
d. STREET ADDRESS: 5412 Kansas Ave. NW.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

075

3. NAME OF DECEASED (Type or print): First Harry Middle Lee Last Hoult Jr.
4. DATE OF DEATH: Month 12 Day 20 Year 1959
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-25-98
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Post Office dept
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): W. Va
12. CITIZEN OF WHAT COUNTRY? Amer.
13. FATHER'S NAME: Harry Lee Hoult
14. MOTHER'S MAIDEN NAME: Sarah Lemen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ✓ (If yes, give war or dates of service): WWI Army
16. SOCIAL SECURITY NO.:
INFORMANT: p't Chart Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 4 years
177X
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 8/12, 1947, to 12-20-59, 19__, that I last saw the deceased alive on 12-20-59, 19__, and that death occurred at 7:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus Harding M.D.
ADDRESS (Street, city or town, state): 113 Carroll St NW Wash 12 DC
DATE SIGNED:
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-23-59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md
23. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home
ADDRESS: 4812 Ga Ave NW DC
24a. REC'D BY REGISTRAR DATE: DEC 28 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13925

CERTIFICATE OF DEATH

Reg. Dist. No. 13876

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 51 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie — 02X-2
d. STREET ADDRESS: 4 Saint Agnes Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First: Okema; Middle: May; Last: Huffman
4. DATE OF DEATH: Month: December; Day: 23; Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 7, 1951
9. AGE (In years last birthday): 8 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Otuce Huffman
14. MOTHER'S MAIDEN NAME: Orada Bostic
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Gastro-intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 Hours

204.3

DUE TO (b) Acute Lymphatic Leukemia — 6 Mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 2, 1959 to December 23, 1959 that I last saw the deceased alive on December 23, 1959, and that death occurred at 1:25 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles E. Mengel M.D. — ADDRESS (Street, city or town, state): The Clinical Center — DATE SIGNED: 12-23-59

PHYSICIAN'S NAME (Type): Charles E. Mengel, M. D. — National Institutes of Health, Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/24/59
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City, town, or county) (State): GlenBurnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR — DATE: DEC 28 '59
24b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13877

Reg. Dist. No. 13926

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USNH, NNMC, BETHESDA, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 6806 Granby Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle L. Last HULLINGHORST
4. DATE OF DEATH: Month Dec. Day 10 Year 19 59
5. SEX: M
6. COLOR OR RACE: Cau
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept-9-1916
9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Col. MC USA
10b. KIND OF BUSINESS OR INDUSTRY: U S Army
11. BIRTHPLACE (State or foreign country): TELA - HONDURAS
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: GEORGE J. Hullinghorst
14. MOTHER'S MAIDEN NAME: ROSA WARREN.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1934-1959
16. SOCIAL SECURITY NO.: 212-38-8033
17. INFORMANT: JEAN I Hullinghorst. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☑
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12/10/59
EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/15/59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
22d. LOCATION (City, town, or county) (State): Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE: Michael J. Rinaldi
ADDRESS: 816 H St., N. E. Washington 2, D. C.
Rinaldi Funeral Home
24a. REC'D BY REGISTRAR DATE DEC 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13927 **CERTIFICATE OF DEATH** Reg. Dist. No. 13878

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 52 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3216 Edgewood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charlotte; Middle: (None); Last: Jackson

4. DATE OF DEATH: Month: December; Day: 10; Year: 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 25, 1926
9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None (Housewife)
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: David L. Alpert
14. MOTHER'S MAIDEN NAME: Sophia Stein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unascertainable
INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) P Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
190.9
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Massive pulmonary infiltration and hemothorax — days
DUE TO
(c) Malignant melanoma — 22 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 19, 19 59, to December 10, 19 59 that I last saw the deceased alive on December 10, 19 59, and that death occurred at 3:05 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard C Mechanic M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 12-10-59
PHYSICIAN'S NAME (Type): Richard C. Mechanic, M. D.

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: DEC. 11, 1959
22c. NAME OF CEMETERY ~~OR CREMATORY~~: MT. LEBANON CEMETERY
22d. LOCATION (City, town, or county): HYATTSVILLE (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: B. DANZANSKY & SONS
ADDRESS: 3501-14th St. N.W.
24a. REC'D BY REGISTRAR DATE: DEC 14 '59
24b. REGISTRAR'S SIGNATURE: Clifford L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13879

Reg. Dist. No. 13879

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8913 Brookville Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 8913 Brookville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Middle: Henderson Last: James
4. DATE OF DEATH: Month: Dec Day: 7 Year: 1959
5. SEX: Fem
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-9-26
9. AGE (In years last birthday): 33 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James A Henderson
14. MOTHER'S MAIDEN NAME: Mary Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Leroy James — Address: Iten 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of left breast with — INTERVAL BETWEEN ONSET AND DEATH: 6 mo
170 X
DUE TO (b): Metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-8-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/10/59
22c. NAME OF CEMETERY OR CREMATORY: Ash Memorial.,
22d. LOCATION (City, town, or county) (State): Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Robert K. Snowden — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE DEC 15 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13929

13880

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9301 Weaver St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17302 Takoma Park
d. STREET ADDRESS Patterson Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First LEOKADIA Middle JASHEMSKI Last
4. DATE OF DEATH Month Dec. Day 23 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH Jan. 1, 1888
9. AGE (In years lost birthday) 71 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Joseph Radzejewski
14. MOTHER'S MAIDEN NAME Marya
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Stanley A. Jashemski Address 415 Pershing St. SSMd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Severe generalized arteriosclerosis — 10 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 22 December 1959, to 23 December 1959, that I last saw the deceased alive on 22 December, 1959, and that death occurred at 6:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Russell B. Arnold M.D. ADDRESS (Street, city or town, state) 8801 Colesville Road, DATE SIGNED 23 Dec. '59

PHYSICIAN'S NAME (Type) Russell B. Arnold M.D. Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Dec 26, 1959
22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
22d. LOCATION (City, town, or county) (State) York, Nebraska

23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters ADDRESS 254 Carroll St. NW DC
24a. REC'D BY REGISTRAR DATE DEC 28 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Trossa

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG253 12-14-59 et

13930

CERTIFICATE OF DEATH

Reg. Dist. No. 13881

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5821 Bradley Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X 5821 - Bradley Blvd
d. STREET ADDRESS: Bethesda 14
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ALICE Middle: MAY Last: JENKINS

4. DATE OF DEATH: Month: December Day: 5 Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 1 - 1879

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months ~~Days~~ IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMSTRESS

10b. KIND OF BUSINESS OR INDUSTRY: dress shop

11. BIRTHPLACE (State or foreign country): ALEXANDRIA VA

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John T. Evans

14. MOTHER'S MAIDEN NAME: Alice Padgett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 089-03-4460

INFORMANT: Mrs Elva Hunt — Address: SAME

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH: years
422.1
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 1959, to Dec 5, 1959 that I last saw the deceased alive on Nov 11, 1959, and that death occurred at 2:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: DeWitt E. DeLawter M.D. ADDRESS (Street, city or town, state): 8025 ABERDEEN Rd DATE SIGNED: 12/5/59

PHYSICIAN'S NAME (Type): DeWitt E DeLawter M.D. Bethesda 14 Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/7/59

22c. NAME OF CEMETERY OR CREMATORY: Union Cemetery

22d. LOCATION (City, town, or county) (State): ALEXANDRIA VA.

23. FUNERAL DIRECTOR'S SIGNATURE: W. B. Montcastle ADDRESS: Alexandria, Va.
Cunningham Funeral Home, Inc.

24a. REC'D BY REGISTRAR DATE: DEC 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13840

CERTIFICATE OF DEATH

13882

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 25 minis
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring.
d. STREET ADDRESS: 140 Boni-Sant St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kase; Middle: Washington; Last: Jenkins

4. DATE OF DEATH: Month 12 – Day 14 – Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-28-13
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst. Super. of Roads.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Noah Jenkins
14. MOTHER'S MAIDEN NAME: Bertha Fincham.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes. (If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.: 578 10 0491
17. INFORMANT: Hospital Records. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
420.1
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 14, 1959, to Dec 14, 1959, that I last saw the deceased alive on Dec 14, 1959, and that death occurred at 11 15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J Marion Bankhead M.D. — ADDRESS (Street, city or town, state): 9241 Col. Blvd — DATE SIGNED: 12/14/59

PHYSICIAN'S NAME (Type): J. Marion Bankhead — Silver Spring, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 18 59
22c. NAME OF CEMETERY OR CREMATORY: Union
22d. LOCATION (City, town, or county): Burtonsville (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber — ADDRESS: Laytonsville Md.
24a. REC'D BY REGISTRAR: DEC 21 59 DATE
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

Medical Examiner - Dr. Bankhead called and he OK'd his signing this certificate 12/17/59

1 X X

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13841 — 13883 — Reg. Dist. No.

075

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1½ days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. Sanatarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7318 Carroll Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Adolph Last: Jenkins
4. DATE OF DEATH Month: Dec. Day: 19, 1959 Year: 19

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/12/1902
9. AGE (In years on last birthday): 57 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pressman
10b. KIND OF BUSINESS OR INDUSTRY: Metro-Lithograph
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert M. Jenkins
14. MOTHER'S MAIDEN NAME: Gloria Havener

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.II
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Jenkins. Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shock

976 X

DUE TO (b): Hemorrhage & Laceration of left lung — 1½ days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Shot Gun Wound

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self inflected shot gun wound in left chest
20c. TIME OF INJURY: 6:40 o. m. Month, Day, Year: 12/16/59
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Takoma Park (County): Montg. (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12/19/59
EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec.22,1959
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. CHAMBERS CO., ADDRESS: Riverdale, Maryland.
24a. REC'D BY REGISTRAR DATE: DEC 28 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13931

Reg. Dist. No. 13884

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 25 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY COUNTY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING, MARYLAND
d. STREET ADDRESS: 721 MC NEIL LANE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

073

3. NAME OF DECEASED (Type or print): First: JEFFERY Middle: BRIAN Last: JENNINGS

4. DATE OF DEATH: Month: DECEMBER Day: 5 Year: 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/4/59

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: Days: 1 IF UNDER 24 HRS.: Hours: 11 Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES QUINTON JENNINGS

14. MOTHER'S MAIDEN NAME: GRACE EVELYN SCHUSTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: HOSPITAL RECORDS Address: OLNEY, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital anomalies of Heart — INTERVAL BETWEEN ONSET AND DEATH: 1 day
754.5
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple Congenital defects

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/4, 1959, to 12/5, 1959, that I last saw the deceased alive on 12/5, 1959, and that death occurred at 10:58 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): SANDY SPRING, MARYLAND

DATE SIGNED: 12/5/59

PHYSICIAN'S NAME (Type): C. H. LIGON, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 7, 1959

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Prince George's Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphreys, Inc. ADDRESS: 8434 Georgia Ave., Silver Spring, Md.

Raymond C. Jeka

207339-XV4

24a. REC'D BY REGISTRAR DATE: DEC 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

~~13932~~ Reg. Dist. No. 13885

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pro George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 6821 Pineway 1615-2
d. STREET ADDRESS: Hyattsville Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELIZABETH Middle: S. Last: JOHNSON
4. DATE OF DEATH: Month: December Day: 9 Year: 1959
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan 23, 1866
9. AGE (In years last birthday): 93 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Adam Sausen
14. MOTHER'S MAIDEN NAME: Mary Schmidt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr Rayburn H Bamberg — Address: Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE
444x
DUE TO
(b) ESSENTIAL HYPERTENSION
DUE TO
(c) GENERALIZED ARTERIOSCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SENILITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 10, 1958 to Dec. 9, 1959, that I last saw the deceased alive on Dec. 9, 1959, and that death occurred at 2:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas Fondey M.D. — ADDRESS (Street, city or town, state): 5206 Norway St. — DATE SIGNED
PHYSICIAN'S NAME (Type): Cherry Chase, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec 12, 1959
22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville, Maryland
24a. REC'D BY REGISTRAR — DATE: DEC 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages [illegible] and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13886

13859 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 3 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Stony Creek Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Rockville
d. STREET ADDRESS: Stony Creek Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Otho Last: Johnson Jr
4. DATE OF DEATH: Month: Dec Day: 25 Year: 1959
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-15-1913
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wm O. Johnson
14. MOTHER'S MAIDEN NAME: Lillian Knott
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes If yes, give war or dates of service: WW II
16. SOCIAL SECURITY NO.: 579-05-7549
17. INFORMANT: Daisy Johnson (wife) Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carbon monoxide poisoning
973.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found on floor of closed garage
20c. TIME OF INJURY: Hour 3:15 ~~a.m.~~ p.m. Month, Day, Year 12-25 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Rockville (County): Monty (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-25-59
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-28-59
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: DEC 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kind

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Item 18 Film 255 12-18-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13933

Reg. Dist. No. 13887

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 2 HRS. 50 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY COUNTY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MOMTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAITHERSBURG
d. STREET ADDRESS: 11 RUSSELL AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

073

3. NAME OF DECEASED (Type or print): First LEE — Middle ALLNUTT — Last JONES

4. DATE OF DEATH: Month DECEMBER — Day 6 — Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11/18/92

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK - MONTGOMERY

10b. KIND OF BUSINESS OR INDUSTRY: Co. ROAD DEPT.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: GEORGE DARBY JONES

14. MOTHER'S MAIDEN NAME: EVA WILES ALLNUTT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) War I-Army

16. SOCIAL SECURITY NO. 220-26-2564

17. INFORMANT: HOSPITAL RECORDS — Address: OLNEY, MARYLAND

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Undetermined — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.
795.5
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

2

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12/7/59

EXAMINER'S NAME (Type): FRANK J. BROSCHART, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: 12/9/59
22c. NAME OF CEMETERY OR CREMATORY: Monocacy
22d. LOCATION (City, town, or county) (State): Beallsville Md

23. FUNERAL DIRECTOR'S SIGNATURE: William B. Helton — ADDRESS: Barnesville Md

24a. REC'D BY REGISTRAR — DATE: DEC 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)
5M 9/55

1

M

I

2

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13934

CERTIFICATE OF DEATH

Reg. Dist. No. 13888

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda 14
d. STREET ADDRESS: 7608 Newmarket Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First: Ethlyn — Middle: Rita — Last: Kassel

4. DATE OF DEATH: Month: December — Day: 10 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: September 19, 1906
9. AGE (In years lost birthday): 53 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Librarian
10b. KIND OF BUSINESS OR INDUSTRY: Library
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Sol Cohn
14. MOTHER'S MAIDEN NAME: Theresa Luster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): hepatic coma
170 X
DUE TO (b): metastatic cancer of breast with metastases to lungs, bone, and liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: hours — 3½ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): gastrointestinal bleeding - ? due to liver disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 8, 1959, to December 10, 1959 that I last saw the deceased alive on December 10, 1959, and that death occurred at 7:15 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: John L. Lewis Jr. M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 12-10-59
PHYSICIAN'S NAME (Type): JOHN L. LEWIS JR., M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: DEC. 11, 1959
22c. NAME OF CEMETERY OR CREMATORY: BNAI ISRAEL CEMETERY
22d. LOCATION (City, town, or county): OXON HILL — (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: B. DANZANSKY & SONS — ADDRESS: 3501-14th St. N.W.
24a. REC'D BY REGISTRAR — DATE: DEC 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kiess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13935 Reg. Dist. No. 13889

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3700 Adams Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X KENSINGTON
d. STREET ADDRESS: 3112 McComas Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS Middle WALTER Last KIRK
4. DATE OF DEATH: Month December Day 18 Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/25/81
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Excavating contractor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry C. Kirk
14. MOTHER'S MAIDEN NAME: Alice E. Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Bertha A. Kirk, 3112 McComas Ave. Kensington, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Two Days
DUE TO
(b) Bronchopneumonia — Two Weeks
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
491 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Old Cerebro-Vascular Accident
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1959, to Dec 18, 1959, that I last saw the deceased alive on Dec 18, 1959, and that death occurred at 3:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert T. Thibadeau M.D. ADDRESS (Street, city or town, state): 10609 Concord St. DATE SIGNED: Dec 18, 1959

PHYSICIAN'S NAME (Type): Robert T. Thibadeau, M.D. Kensington, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/21/59
22c. NAME OF CEMETERY OR CREMATORY: COLESVILLE METHODIST CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond F. Pumphrey WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: DEC 22 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13936

CERTIFICATE OF DEATH

Reg. Dist. No. 13890

1. PLACE OF DEATH a. COUNTY: Montgomery ~~Kent County~~ MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown

c. LENGTH OF STAY IN 1b: unknown

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 47x-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Marylander Nursing Home

d. STREET ADDRESS: 1882 Columbia Rd. N. W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma Middle B. Last Kistler

4. DATE OF DEATH: Month December Day 2 Year 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: unknown

9. AGE (In years last birthday): 81 ? yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - U. S. Government

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry C. Bowen

14. MOTHER'S MAIDEN NAME: Julia Childs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

INFORMANT: James B. Straughn - Laurel, Maryland Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH 10 years.

422.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 1, 1959, to Dec. 3, 1959, that I last saw the deceased alive on Nov 29, 1959, and that death occurred at 9:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE James P. Kerr M.D. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED

PHYSICIAN'S NAME (Type) James P. Kerr

22a. BURIAL, CREMATION, REMOVAL (Specify): cremation

22b. DATE THEREOF: 12/2/59

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln crematory

22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. ADDRESS: Washington, D. C.

24a. REC'D BY REGISTRAR DATE DEC 3 '59

24b. REGISTRAR'S SIGNATURE: Cathy L. Knous

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13842

CERTIFICATE OF DEATH

Reg. Dist. No. 13891

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 8 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park.
d. STREET ADDRESS 7312 Flower Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

075

3. NAME OF DECEASED (Type or print) First: Carl Middle: Oakford Last: Klein
4. DATE OF DEATH Month: 12 Day: 15 Year: 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 11-25-82
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Salesman - Cemetery
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Klein.
14. MOTHER'S MAIDEN NAME Mary Alice Jones.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Spanish American. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Son-in-law. Address

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 260 X — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) Cardio vascular Renal Disease — Chronic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) Diabetes Mellitus — Chronic
Coronary Thrombosis Myocardial infarction — 6 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Summer, 1925, to Dec. 15, 1959, that I last saw the deceased alive on Dec 15, 1959, and that death occurred at 12:15 noon, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED 12/17/59

ACTUAL SIGNATURE Frank C. Willman M.D.

PHYSICIAN'S NAME (Type) Frank C. Willman 2731 Connecticut Wash D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12-17-59
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill
22d. LOCATION (City, town, or county) Suitland (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home
ADDRESS Wash. D.C.
24a. REC'D BY REGISTRAR DATE DEC 18 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Hiatt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13843

CERTIFICATE OF DEATH

Reg. Dist. No. 13892

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 hr & 55 min's
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7809 Greenwood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Goldie — Middle: MMN — Last: Knight
4. DATE OF DEATH: Month: 12 — Day: 4 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-29-94
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: Brison Hickson
14. MOTHER'S MAIDEN NAME: Unknown to pt's husband
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: pt Chart — Address:

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
331X
DUE TO (b): Hypertension — 23 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 3, 1956 to 4 Dec, 1959, that I last saw the deceased alive on 4 Dec, 1959, and that death occurred at 7:40 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Russell B. Arnold M.D. — ADDRESS (Street, city or town, state): 8801 Colesville Road — DATE SIGNED: 12/4/59

PHYSICIAN'S NAME (Type): Russell B. Arnold M.D. Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 8, 1959
22c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery
22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St. N. Wash. 12, D.C.
24a. REC'D BY REGISTRAR: DATE DEC 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

Coroner ~~Coroner~~ notified & approved Dr Arnold signing certificate

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13893

CERTIFICATE OF DEATH

Reg. Dist. No. 215

13937

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda Md.

051

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. STREET ADDRESS: 2500 Wisconsin Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lewis — Middle: "L" — Last: KNIGHT
4. DATE OF DEATH: Month: December — Day: 1 — Year: 19 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-7-11
9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govenment
11. BIRTHPLACE (State or foreign country): Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Low L. KNIGHT
14. MOTHER'S MAIDEN NAME: Isabella BRAZEALE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1930-1953
16. SOCIAL SECURITY NO.: 527-46-3487
INFORMANT: (Wife) Virginia B. Knight — Address: Same as #2

1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cor pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
002 X
DUE TO
(b) Pulmonary emphysema, endobronchial — 6 years
DUE TO
(c) tuberculosis bronchogenic carcinoma — 6 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 162.1
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 29 November, 1959, to 1 December, 19 59, that I last saw the deceased alive on 1 December, 19 59, and that death occurred at 3:59 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Vernon N. Houk M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda Md. — DATE SIGNED: 12-1-59

PHYSICIAN'S NAME (Type): V.N. HOUK LT MC USN — U.S. Naval Hospital, NNMC, Bethesda Md.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-5-59
22c. NAME OF CEMETERY OR CREMATORY: Oakland cemetery
22d. LOCATION (City, town, or county) (State): Hendersonville North Carolina

23. FUNERAL DIRECTOR'S SIGNATURE: Robert E. Deal — ADDRESS: De Vol 2224 Wisconsin Ave. Washington, D.C.
24a. REC'D BY REGISTRAR: DATE DEC 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13894

CERTIFICATE OF DEATH

13938

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4209 GLENROSE ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d. STREET ADDRESS: 4209. GLENROSE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMIL — Middle W. — Last KRYZ

4. DATE OF DEATH: Month DEC. — Day 8 — Year 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/12/92
9. AGE (In years lost birthday): 67 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONTRACTOR
10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION
11. BIRTHPLACE (State or foreign country): OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-28-7201
INFORMANT: Mrs. Bertha H. Kryz, 4209 Glenrose Rd. Bethesda, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — — INTERVAL BETWEEN ONSET AND DEATH: 4-5 days
294 X
DUE TO (b) Polycythemia - Vera — — 1 year -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Fibrillation —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/17/58, 19__, to 12/8/59, 19__, that I last saw the deceased alive on 12/8/59, 19__, and that death occurred at 12:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James A. O'Keeffe M.D.
PHYSICIAN'S NAME (Type): James A O'Keeffe MD — ADDRESS (Street, city or town, state): 4501 Cross Ave Mo Louis Mo — DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/11/59
22c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. — ADDRESS: SILVER SPRING, MD.
Raymond A. Ziska
24a. REC'D BY REGISTRAR — DATE: DEC 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13895

13844

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 16 Wessex Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

075

3. NAME OF DECEASED (Type or print): First: George; Middle: (N.M.N.); Last: Kuhn
4. DATE OF DEATH: Month: Dec.; Day: 7; Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-3-00
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Research Engineer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Kuhn
14. MOTHER'S MAIDEN NAME: Natasha ?Unknown to Family
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes) give war or dates of service: —
16. SOCIAL SECURITY NO.: —
INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 days
420.1
DUE TO
(b) Coronary Thrombosis — 15 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1956 to Dec. 7, 1959 that I last saw the deceased alive on December 6, 1959, and that death occurred at 6:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James M. Alters M.D.
ADDRESS (Street, city or town, state): 7701 Carroll Ave Takoma Park 12 Md.
DATE SIGNED: 12-7-59
PHYSICIAN'S NAME (Type)

1

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
22b. DATE THEREOF: Dec 9, 1959
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
22d. LOCATION (City, town, or county) (State): Prince Georges Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: 254 Carroll St. N.W.
24a. REC'D BY REGISTRAR DATE DEC 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13939

CERTIFICATE OF DEATH

13896

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

M

050

I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 89 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington — 83x-3
d. STREET ADDRESS: 5912 North 9th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eve; Middle: (None); Last: Laiken

4. DATE OF DEATH: Month: December; Day: 28; Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 4, 1904
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: David Feldman
14. MOTHER'S MAIDEN NAME: Lena Goodman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 229-44-5744 ~~Unreported 1959~~
INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) hemopericardium & bleeding duodenal ulcer — INTERVAL BETWEEN ONSET AND DEATH: days
442x
DUE TO
(b) cardiac decompensation — weeks
DUE TO
(c) chronic renal disease with uremia — months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from September 30 1959, to December 28, 1959, that I last saw the deceased alive on December 28, 1959, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Laurence E. Earley M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: December 29, 1959

1

PHYSICIAN'S NAME (Type): LAURENCE E. EARLEY, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/31-1959
22c. NAME OF CEMETERY OR CREMATORY: Natl Mem Park
22d. LOCATION (City, town, or county): Falls Church (State): Va

23. FUNERAL DIRECTOR'S SIGNATURE: Goldberg Funeral Home — ADDRESS: 4217 9th NW DC
24a. REC'D BY REGISTRAR: DATE JAN 4 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13845

CERTIFICATE OF DEATH

Reg. Dist. No. 13897

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San. and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 411 Silver Spring Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

075

3. NAME OF DECEASED (Type or print): First: Michael; Middle: Joseph; Last: Lane
4. DATE OF DEATH: Month: 12; Day: 13; Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑
8. DATE OF BIRTH: 12-5-85
9. AGE (In years lost birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Retired - Govt Employee CLERK
10b. KIND OF BUSINESS OR INDUSTRY: Postal Dept. U.S. Gov't.
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: unknown Lane
14. MOTHER'S MAIDEN NAME: unknown Shea
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.I
16. SOCIAL SECURITY NO.: 271-05-9201
INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): Hypertensive Heart Disease
DUE TO (c): Hypertension

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/16/56, 19__, to Dec 13, 1959, that I last saw the deceased alive on Dec 13, 1959, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip E. Jones M.D. — ADDRESS (Street, city or town, state): 918 Ellsworth Drive — DATE SIGNED: 12/13/59

PHYSICIAN'S NAME (Type): Philip E. Jones — Silver Spring, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/17/59
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY
22d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Fiske — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE DEC 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13940

CERTIFICATE OF DEATH

13898

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 71 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Flordia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Petersburg 48 x-3
d. STREET ADDRESS: 2835 29th Avenue North
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

051

3. NAME OF DECEASED (Type or print): First: John — Middle: (n) — Last: LAW
4. DATE OF DEATH: Month: December — Day: 30 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-12-07
9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John LAW
14. MOTHER'S MAIDEN NAME: Fanny BRANNAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: (Wife) Mrs. Helen A Law — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH
162.1
DUE TO
(b) c multiple metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 20 October, 19 59, to 30 December, 19 59, that I last saw the deceased alive on 30 December, 19 59, and that death occurred at 6:50P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John Walter Lewis M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda Md. — DATE SIGNED: 12-30-59

PHYSICIAN'S NAME (Type): J.M. LEWIS LT MC USNR — U.S. Naval Hospital, NNMC, Bethesda Md.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-4-60
22c. NAME OF CEMETERY OR CREMATORY: Peacedale Cemetery
22d. LOCATION (City, town, or county) (State): Highland Falls, New York

23. FUNERAL DIRECTOR'S SIGNATURE: Rinaldi — ADDRESS: 816 "H" Street N.E. Washington, D.C.
24a. REC'D BY REGISTRAR: DATE JAN 5 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13846 13899

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 321 W. ST NE. Wash DC.
d. STREET ADDRESS: 47x-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Howard Middle William Last Lawhorn
4. DATE OF DEATH: Month 12 Day 7 Year 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-1-84
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (Retired)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Amherst Co. ~~Leesburg~~ Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Fitz Patrick Lawhorn
14. MOTHER'S MAIDEN NAME: Ida Kite Grant
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578096398
17. INFORMANT: Mrs Catherine Lawhorn Address: 8423 12th Ave Langley Park Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b): Cerebrovascular — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.V.A. about 3 yrs ago
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-7-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 10, 1959
22c. NAME OF CEMETERY OR CREMATORY: FT. HILL BURIAL PARK
22d. LOCATION (City, town, or county) (State): LYNCH BURG. VA.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St. NW
24a. REC'D BY REGISTRAR DATE DEC 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

1

Item 20 Film 255 12-23-59 ams

13941

13900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5006 Hampden Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 5006 Hampden Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: M; Last: Lehman

4. DATE OF DEATH: Month: Dec.; Day: 7; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 1, 1868

9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months: 11; Days: 6 — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Washington D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Michael O'Connor

14. MOTHER'S MAIDEN NAME: Ellen Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

INFORMANT: Marie L. Kealy-daughter-same as 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Fractured Hip — 7 Months
DUE TO
(c): Generalized Arteriosclerosis — YEARS
904.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Leaning over to pick up a string & fell - taken to Suburban Hospital & surgery performed 10 pm that nite

20c. TIME OF INJURY: Hour 6 p. m. — Month, Day, Year: May 29 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Her Home

20f. (City or town): Bethesda (County): Mont. (State): Maryland

21. I certify that I attended the deceased from May, 1956, to Dec 7, 1959, that I last saw the deceased alive on Dec 6, 1959, and that death occurred at 8 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo I. Donovan M.D. — ADDRESS (Street, city or town, state): 8016 Georgetown Rd Bethesda Md — DATE SIGNED: 12/8/59

PHYSICIAN'S NAME (Type): Leo I. Donovan, M.D. 8016 Old Georgetown Rd. Bethesda Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/10/59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR: DATE DEC 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13942

Reg. Dist. No. 13901

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Y ork
b. COUNTY: 69X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New York City (Brooklyn)
d. STREET ADDRESS: 903 Avenue S
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First: Michael; Middle: Allen; Last: Lorowitz
4. DATE OF DEATH: Month: December; Day: 8; Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 15 May 1956
9. AGE (In years last birthday): 3 yrs. — IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): New Y ork
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Herman Z. Lorowitz
14. MOTHER'S MAIDEN NAME: Estelle Kramer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive gastro - intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
204.3
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute lymphocytic leukemia — 15 months
DUE TO
(c)

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 17, 19 59, to December 8, 19 59 that I last saw the deceased alive on December 8, 19 59, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles E. Mengel M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED: 12/8/59

PHYSICIAN'S NAME (Type): Charles E. Mengel M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-9-1959
22c. NAME OF CEMETERY OR CREMATORY: Globe Tifore Cem
22d. LOCATION (City, town, or county) (State): Springfield L.I.
23. FUNERAL DIRECTOR'S SIGNATURE: Goldberg — ADDRESS: Funeral Home, Flushing
24a. REC'D BY REGISTRAR: DATE DEC 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13943

Reg. Dist. No. 13902

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 1½ years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9533 East Bexhill Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Kensington
d. STREET ADDRESS: 9533 East Bexhill Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MINNIE — Middle P — Last LOWER

4. DATE OF DEATH: Month December — Day 10 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/5/1871
9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months 9, Days 5 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Charles Potter
14. MOTHER'S MAIDEN NAME: Lavinia Hartley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 511-12-9186-A
INFORMANT: Mrs. L. B. Crabbs-daughter-same 2d — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes
332X
DUE TO
(b) Arteriosclerosis — 10 years
DUE TO
(c) —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 1, 1959, to Dec. 10, 1959 that I last saw the deceased alive on Dec 5, 1959, and that death occurred at 2 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifton R. Gruver M.D. — ADDRESS (Street, city or town, state): 4325 49th St. N.W. Wash. DC — DATE SIGNED: 12/10/59

PHYSICIAN'S NAME (Type): Clifton R. Gruver — 4325-49th St. N. W. Wash. D. C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 12/10/59
22c. NAME OF CEMETERY OR CREMATORY: Washington Cemetery
22d. LOCATION (City, town, or county) (State): Washington, Kansas

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR — DATE: DEC 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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Item 9 FilmG254 12-30-59 et

Lucas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13944

Reg. Dist. No. 13903

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Carrol Hall
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 4903 Montgomery Lane
d. STREET ADDRESS: Bethesda, Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First: Nelle — Middle: G. — Last: Lucas

4. DATE OF DEATH: Month: 12 — Day: 18 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 5, 1895

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months: 3 — Days: 13

IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Kendrick

14. MOTHER'S MAIDEN NAME: Sacks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Yes-Unknown

INFORMANT: William Lucas-son-same as 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
420.1
DUE TO
(b): arterio sclerosis generalized
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-2, 1959, to 12-18, 1959, that I last saw the deceased alive on 12-18, 1959, and that death occurred at 8.55 p.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred S. Norton M.D. — **ADDRESS** (Street, city or town, state): Bethesda Md — **DATE SIGNED**: 12-18-59

PHYSICIAN'S NAME (Type): Alfred S. Norton — Bethesda, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit

22b. DATE THEREOF: 12/20/59

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

22d. LOCATION (City, town, or county) (State): Jacksonville, Florida

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — **ADDRESS**: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: DEC 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13945

CERTIFICATE OF DEATH

13904
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
c. LENGTH OF STAY IN 1b: 35 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4321 Leland Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CHEVY CHASE
d. STREET ADDRESS: 4321 Leland Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle AGNES — Last MAGRUDER

4. DATE OF DEATH: Month DEC. — Day 17 — Year 59

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/21/82
9. AGE (In years lost birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress (retired)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES LEAMAN
14. MOTHER'S MAIDEN NAME: EVELYN M. GLOYD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 577-50-2558
INFORMANT: Mr. John H. Magruder, Sr.,
Address: 1024 Paul Drive, Rockville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONset AND DEATH: 1 yr.
420.0
DUE TO (b) Arteriosclerosis, general — 5 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from OCT. 19 58 to DEC 17 19 59, that I last saw the deceased alive on DEC. 17 19 59, and that death occurred at 7 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo M. Curtis M.D.
ADDRESS (Street, city or town, state): 8218 Wisconsin Ave. Bethesda, Maryland
DATE SIGNED: 12/17/59
PHYSICIAN'S NAME (Type): LEO M. CURTIS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/21/59
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Zeska
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE DEC 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

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074

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13946

CERTIFICATE OF DEATH

Reg. Dist. No. 13905

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 14 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
d. STREET ADDRESS 5311 Roosevelt St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Paula Middle E. Last Mahler
4. DATE OF DEATH Month December Day 21 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH March 4, 1892
9. AGE (In years lost birthday) 67 yrs. IF UNDER 1 YEAR Months 9 Days 17 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician
10b. KIND OF BUSINESS OR INDUSTRY private pract.
11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Antone Treidl
14. MOTHER'S MAIDEN NAME Louise Kastner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
INFORMANT Montreal, Canada Address Sister Louise Treidl-Kahn-8514 Cote St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock — INTERVAL BETWEEN ONSET AND DEATH

451X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Blood loss, hypotension — 1 day

DUE TO (c) Ruptured abdominal aortic aneurysm — 14 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 1954 to 12-21-59, that I last saw the deceased alive on 12-21-59, and that death occurred at 12:17 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE John O Robben M.D. ADDRESS (Street, city or town, state) 7930 Georgia Ave Silver Spring Md DATE SIGNED 12-21-59

PHYSICIAN'S NAME (Type) John O. Robben 7930 Georgia Ave. Silver Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF 12/23/59
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State) Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE DEC 28 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13847

Reg. Dist. No. 13906

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 9808 Colesville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: Childs — Last: McCeney

4. DATE OF DEATH: Month: 12 — Day: 23 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 5-1-1888

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Worker

10b. KIND OF BUSINESS OR INDUSTRY: Road Construction — Self employed

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: George B. McCeney

14. MOTHER'S MAIDEN NAME: Margaret E. Childs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days
420.1
DUE TO
(b) Myocardial infarction — 1 month
DUE TO
(c) Coronary Thrombosis — 1 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1951, to Dec. 23, 1959, that I last saw the deceased alive on Dec 22, 1959, and that death occurred at 4:35 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Merrill M. Cross M.D. — ADDRESS (Street, city or town, state): 8248 GEORGIA AVE. — DATE SIGNED: 12/23/59

PHYSICIAN'S NAME (Type): MERRILL M. CROSS — SILVER SPRING, MARYLAND.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12/26/59

22c. NAME OF CEMETERY OR CREMATORY: St. Mark's Episcopal Cemetery, Montgomery County, Md.

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. — ADDRESS: SILVER SPRING, MD.
Raymond A. Fiska

24a. REC'D BY REGISTRAR DATE DEC 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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13947

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13947

CERTIFICATE OF DEATH

Reg. Dist. No. 215

M

051

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 109 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Indiana
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Evansville 52x-3
d. STREET ADDRESS: 511 E. Franklin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Lawrence — Last: MC DANIEL

4. DATE OF DEATH: Month: December — Day: 21 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6-9-27

9. AGE (In years lost birthday): 32 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Marine Corps

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Isaac MC DANIEL

14. MOTHER'S MAIDEN NAME: Evelyn FITZGERALD

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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.:

INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 36 hours
DUE TO
(b) Rheumatic Heart Disease — 2½ years
DUE TO
(c)

1416x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 3 September, 1959, to 21 December, 1959, that I last saw the deceased alive on 21 December, 1959, and that death occurred at 4:00AM, from the causes and on the date stated above.

ACTUAL SIGNATURE James M. Young M.D. — **ADDRESS** (Street, city or town, state): U.S. Naval Hospital, Bethesda Md. — **DATE SIGNED**: 12-21-59

PHYSICIAN'S NAME (Type): J.M. Young LT MC USN — U.S. Naval Hospital, Bethesda Md.

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22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-24-59

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or county) (State): Evansville Ind.

23. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co by Lyson — **ADDRESS**: W.W. Chambers Funeral Home 1400 Chapin St. N.W. Washington, D.C.

24a. REC'D BY REGISTRAR: DEC 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13948

Reg. Dist. No. 13908

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Rockville
d. STREET ADDRESS: 1005 – Crawford Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ann; Middle: Elizabeth; Last: McHugh

4. DATE OF DEATH: Month: 12; Day: 31; Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 10/7/17
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: US Gov.
11. BIRTHPLACE (State or foreign country): FLORIDA
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: LOUIS A. SMITH
14. MOTHER'S MAIDEN NAME: ESTHER HINSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 579-09-7749
INFORMANT: MARY LOU SAUR
Address: 5321 South wick St Bethesda MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral anoxia — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
705.4
DUE TO (b): Lupus Erythematosus — 6 mons
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 1, 1959, to 12/31, 1959, that I last saw the deceased alive on 12/31, 1959, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen N. Jones M.D. ADDRESS (Street, city or town, state): Rockville, Md DATE SIGNED: 12/31/59

PHYSICIAN'S NAME (Type): Stephen N. Jones

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JAN. 4, 1960
22c. NAME OF CEMETERY OR CREMATORY: GATE of HEAVEN
22d. LOCATION (City, town, or county) (State): WHEATON. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Tallmell ADDRESS: 3603 14th St NW
24a. REC'D BY REGISTRAR DATE: JAN 5 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13949 — Reg. Dist. No. 13909

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2½ hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2212 Colston Dr

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4838 Broadbrook Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arnold; Middle: Bennett; Last: McKee

4. DATE OF DEATH: Month: Dec; Day: 22; Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 11-15-1898
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months: 1; Days: 7
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): auto dealer
10b. KIND OF BUSINESS OR INDUSTRY: Own Business
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: William C. McKee
14. MOTHER'S MAIDEN NAME: Adelaide Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — If yes, give war or dates of service: — — — — — —
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT — Address: Georgeanna McKee-Item #2-Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2½ hrs
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of previous coronary disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BROSCHART
DATE SIGNED: 12-22-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-26-59
22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
22d. LOCATION (City, town, or county) (State): Silver Spring, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
24a. REC'D BY REGISTRAR — DATE: DEC 28 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kirgan

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13950

Reg. Dist. No. 13910

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8819 Kensington Parkway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Kensington
d. STREET ADDRESS: 8819 Kensington Pkwy.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Elizabeth; Last: McLendon

4. DATE OF DEATH: Month: Dec.; Day: 22; Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 9, 1878

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months: 9; Days: 13
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): X S. Carolina

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Robert F. Carnes

14. MOTHER'S MAIDEN NAME: ? Shaw

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

INFORMANT: Virginia Pendleton-daughter-same 2d
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rupture of Aneurysm of Abdominal Aorta — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.
DUE TO
(b) Hypertensive Cardio Vascular Disease — 10 yr.
DUE TO
(c) Arteriosclerosis generalized — 20 yr.

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Coronary insufficiency —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan., 1957, to date, 19__, that I last saw the deceased alive on 22 Dec., 1959, and that death occurred at 3:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John G. Ball — M.D. — ADDRESS (Street, city or town, state): 7936 Old Georgetown Rd. Beth. Md. — DATE SIGNED: 12/22/59

PHYSICIAN'S NAME (Type): John G. Ball

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/24/59

22c. NAME OF CEMETERY OR CREMATORY: Bishopville Cem

22d. LOCATION (City, town, or county) (State): Bishopville, S. Carolina

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR: DATE DEC 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13848

CERTIFICATE OF DEATH

Reg. Dist. No. 13911

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San + Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Spencerville
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): Dr. Willard Payne McNeill
4. DATE OF DEATH: Month Dec. Day 28 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-11-10
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ~~Iowa~~ Maryland
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: Stanley E. McNeill
14. MOTHER'S MAIDEN NAME: Bertha Payne
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Retroperitoneal Renal Undifferentiated — INTERVAL BETWEEN ONSET AND DEATH: 3-6 mo
198.2
DUE TO will
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis to the Brain
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/24, 1959, to 12/29, 1959, that I last saw the deceased alive on 12/28, 1959, and that death occurred at 4:40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas H. Wolohan M.D.
ADDRESS (Street, city or town, state): 7600 Carroll Ave Takoma Park Md
DATE SIGNED: 12/28/59
PHYSICIAN'S NAME (Type): Chas H Wolohan

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 2-1960
22c. NAME OF CEMETERY OR CREMATORY: George Tech - Rom.
22d. LOCATION (City, town, or county) (State): Hyattsville Prince Geo. Md.
23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters
ADDRESS: WASH 13, D.C. 254 Carroll St. N.W.
24a. REC'D BY REGISTRAR DATE: DEC 31 1959
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG254 1-13-60 et

CERTIFICATE OF DEATH

13951

Reg. Dist. No. 13912

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Resmore Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: D. C. b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3

d. STREET ADDRESS: 415 6th st. N. E.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Sue Middle: T. Last: Michie

4. DATE OF DEATH Month: Dec Day: 29 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 1/12/~~1875~~ 1876

9. AGE (In years lost birthday): 83 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Lane

14. MOTHER'S MAIDEN NAME: Mary Twaddell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Col. J. W. Twaddell Address: 2778 Wakefiled Arlington, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Streptococcic abscess — INTERVAL BETWEEN ONSET AND DEATH: 6 days

053.0

DUE TO (b) Cardio vascular disease — 8 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1932 to Dec 29, 1959, that I last saw the deceased alive on Dec 29, 1959, and that death occurred at 6:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: E. E. Quayle M.D. ADDRESS (Street, city or town, state): 1822 Biltmore St. NW. Washington D.C. DATE SIGNED

PHYSICIAN'S NAME (Type): E. E. Quayle

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/2/60

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lee Funeral Home 300 4th St. NE Wash DC

24a. REC'D BY REGISTRAR DATE: DEC 31 59

24b. REGISTRAR'S SIGNATURE: Joseph L. Fedeus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13952 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 13913

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1 wk
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11919 Andrew St.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont'g
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 11919 Andrew St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thelma Middle: D. Last: Miller
4. DATE OF DEATH: Month: Dec Day: 8 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-23-1901
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: Harry Clark
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Suburban Hosp. record — Address: Bethesda Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary occlusion	sudden
DUE TO (b)	arterio-sclerotic heart disease	1 yr
DUE TO (c)		

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hospitalized 1 yr ago for thrombosis left lower leg
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): FRANK J. BROSCHART
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-8-59

2

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-11-59
22c. NAME OF CEMETERY OR CREMATORY: Blairsville
22d. LOCATION (City, town, or county) (State): Blairsville Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Neal Funeral Home
ADDRESS: 4812 Ga. Ave NW
24a. REC'D BY REGISTRAR
DATE: DEC 15 '59
24b. REGISTRAR'S SIGNATURE: Gordon S. Kirk

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13953

Reg. Dist. No. 13914

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47 X-3
d. STREET ADDRESS: 342 13th Street, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First: Myrtle; Middle: Minnie; Last: Mitchell

4. DATE OF DEATH: Month: December; Day: 27; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3 June 1888

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Etta Hunt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578-22-1892

INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
141.9
DUE TO (b) Aspiration of blood from oral hemorrhage — 5 minutes
DUE TO (c) Carcinoma of tongue with metastases — 3 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 21, 1959, to December 27, 1959, that I last saw the deceased alive on December 27, 1959, and that death occurred at 1:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard S. Schwartz, M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 12/27/59
PHYSICIAN'S NAME (Type): HOWARD S. SCHWARTZ

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-30-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. Inc
ADDRESS: Wash. D.C.
24a. REC'D BY REGISTRAR DATE DEC 29 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13954 — Reg. Dist. No. 13915

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY COUNTY GENERAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 15360 Colesville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: William — Last: Moore
4. DATE OF DEATH: Month: Dec — Day: 8 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-6-1892
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Retired Carpenter
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Pope Moore
14. MOTHER'S MAIDEN NAME: Virginia Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 579-07-4409
17. INFORMANT: Cordelia Moore (wife) — Address: Olney

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-8-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec 11, 1959
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Montgomery County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St., N.W.
24a. REC'D BY REGISTRAR: DATE DEC 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13955

13916

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LeDEAU NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING
d. STREET ADDRESS: 8316 Carey Lane,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PETER — Middle: JOSEPH — Last: MORIN

4. DATE OF DEATH: Month: 12 — Day: 10 — Year: 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 10, 1881
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgr. Meat Dept.
10b. KIND OF BUSINESS OR INDUSTRY: Safeway Stores, Inc.
11. BIRTHPLACE (State or foreign country): CANADA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: XAVIER MORIN
14. MOTHER'S MAIDEN NAME: PHILOMENA GAUTIER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 577-09-2717
17. INFORMANT: Mrs. Rgina M. Morin, Address: 8316 Carey Lane Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days
332X
DUE TO (b): Cerebral arteriosclerosis — several years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Terminal bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-26, 1959 to 12-10, 1959 that I last saw the deceased alive on 12-9, 1959, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Jason Geiger M.D.
ADDRESS (Street, city or town, state): 931 Pershing Dr. Silver Spring, Md.
DATE SIGNED: 12-11-59
PHYSICIAN'S NAME (Type): JASON GEIGER

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/14/59
22c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Jaska
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: DEC 16 '59
24b. REGISTRAR'S SIGNATURE: Clifford S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

I

2

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13956

CERTIFICATE OF DEATH

13917

Reg. Dist. No. 215

051

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 65 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital NNMC

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Florida
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Key West 48 x-3
d. STREET ADDRESS: Avenue E Big Coppitt Key
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorothy Middle: Lorraine Last: Mosier

4. DATE OF DEATH: Month: December Day: 12 Year: 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2 May 1924
9. AGE (In years lost birthday): 35 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Conn.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Barney Belgrade
14. MOTHER'S MAIDEN NAME: Rose Unk.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Carcinomatosis — 6 mos.

199.2

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Papillary Serous Cyst Adno Carcinoma

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8 October, 19 59, to 12 December, 19 59, that I last saw the deceased alive on 12 December, 19 59, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.H. Perkins M.D.
ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda Md.
DATE SIGNED: 12-14-59

PHYSICIAN'S NAME (Type): R.H. PERKINS LT MC USN — U.S. Naval Hospital, Bethesda Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-15-59
22c. NAME OF CEMETERY OR CREMATORY: Jewish Cemetery
22d. LOCATION (City, town, or county) (State): Waterford Conn.

23. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home
ADDRESS: Deal Funeral Home Washington, D.C. 4812 Ga. Ave
24a. REC'D BY REGISTRAR DATE: DEC 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13957

CERTIFICATE OF DEATH

13918

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 8 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY COUNTY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X KENSINGTON
d. STREET ADDRESS: 1 3932 WASHINGTON STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM Middle: CLARENCE Last: MOULDEN

4. DATE OF DEATH: Month: DECEMBER Day: 29 Year: 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/26/77
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meat cutter and Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH MOULDEN
14. MOTHER'S MAIDEN NAME: ANNIE A. BREMMIMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-01-6764
INFORMANT: HOSPITAL RECORDS Address: OLNEY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia, hemorrhagic — INTERVAL BETWEEN ONSET AND DEATH: 7 days
443X
DUE TO
(b) Hypertensive cardiovascular disease — 10 yrs
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/21, 1955, to 12/29, 1955, that I last saw the deceased alive on 12/29, 1955, and that death occurred at 11:22 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: A. D. Bonifant M.D.

PHYSICIAN'S NAME (Type): A. D. BONIFANT, M. D. SANDY SPRING, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1/2/60
22c. NAME OF CEMETERY OR CREMATORY: ROCKVILLE CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Zinka
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE JAN 4 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13958

CERTIFICATE OF DEATH

Reg. Dist. No. 13919

1. PLACE OF DEATH a. COUNTY: M ontgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 12 Hrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: M ontgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda

d. STREET ADDRESS: 6900 M illwood Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

074

3. NAME OF DECEASED (Type or print): First: John Middle: E. Last: M uldoon

4. DATE OF DEATH Month: Dec. Day: 3 Year: 1959

5. SEX: M ale

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/25/85

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Real Estate

11. BIRTHPLACE (State or foreign country): Canada

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Thomas M uldoon

14. MOTHER'S MAIDEN NAME: Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Son) Burke M uldoon Address: (same as Above)

I

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Generalized Carcinomatosis — Unknown

DUE TO

151X

(b) Gastric Carcinoma — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 11/16, 1959, to 12/3, 1959, that I last saw the deceased alive on 12/2, 1959, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Donald Q Ekman M.D. ADDRESS (Street, city or town, state): 5717 Wisconsin Ave Chevy Chase, Md DATE SIGNED: 12/3/59

PHYSICIAN'S NAME (Type): Donald Q. Ekman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/5/59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem.

22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Chevy Chase Funeral Home ADDRESS: 5103 Wis Ave WASH D.C.

24a. REC'D BY REGISTRAR DATE DEC 7 '59

24b. REGISTRAR'S SIGNATURE: Arthur S Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13849

CERTIFICATE OF DEATH

Reg. Dist. No. 13920

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 634 Sligo Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mr. Middle: Thomas Last: James Murphy, SR

4. DATE OF DEATH: Month Dec. Day 29 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 4/17/83

9. AGE (In years lost birthday): 76 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRINTING ANALYST Govt Employee

10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOV'T.

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Patrick C. Murphy

14. MOTHER'S MAIDEN NAME: Elizabeth Gilchen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Gertrude (Silver Spring, Md.) Daughter - 634 Sligo Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Dilitation — INTERVAL BETWEEN ONSET AND DEATH: 2 hr.
DUE TO (b): Generalized Arteriosclerosis — 5 yr.
DUE TO (c):

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 2, 1959, to Dec 29, 1959, that I last saw the deceased alive on Dec 29, 1959, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE LOBWardrop MD **M.D.** **ADDRESS** (Street, city or town, state): 800 Pershing Drive **DATE SIGNED** 12/29/59

PHYSICIAN'S NAME (Type) W. B. WARDROP

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1/2/60

22c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery

22d. LOCATION (City, town, or county) (State): Montgomery County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Zicka

ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: JAN 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kunz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13959

CERTIFICATE OF DEATH

Reg. Dist. No. 13921

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FAIRLAND
c. LENGTH OF STAY IN 1b: 1 yr & 9 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: FAIRLAND NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING
d. STREET ADDRESS: 1 Briggs Chaney Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First CLARA Middle EMMA Last MUSGROVE

4. DATE OF DEATH: Month DEC. Day 1 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 1/1/75

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Briggs

14. MOTHER'S MAIDEN NAME: Frances Beckwith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

INFORMANT: Mrs. Taylor O. Timberlake, Jr. Address: Briggs Chaney Rd., Silver Spring, Md.

1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia, thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
332X
DUE TO
(b) Generalized arteriosclerosis — 10 yr
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 1925, to ~~Nov~~ Dec, 1959 that I lost saw the deceased alive on Nov 28, 1959, and that death occurred at ~~[illegible]~~ 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bonifant M.D. ADDRESS (Street, city or town, state): Sandy Spring, Md. DATE SIGNED: 12/1/59

PHYSICIAN'S NAME (Type): A. D. BONIFANT

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12/4/59

22c. NAME OF CEMETERY OR CREMATORY: BURTONSVILLE UNION CEMETERY

22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Zuka
ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE DEC 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13922

Reg. Dist. No. 13960

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 33 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5601 Greentree Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: G.; Last: Myers

4. DATE OF DEATH: Month: 12; Day: 20; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2/16/84

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief of Audits

10b. KIND OF BUSINESS OR INDUSTRY: Govt.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Myers

14. MOTHER'S MAIDEN NAME: Fannie Hammond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Wife – Dolly T. Myers Address: -same as 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fat embolism of lungs — INTERVAL BETWEEN ONSET AND DEATH: sudden
903.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Fracture of left femur — 2 days
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Ø

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell on floor at home

20c. TIME OF INJURY Hour: ½ a. m. p. m. — Month, Day, Year: 12/18 1959

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f. (City or town): Bethesda (County): Montg. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12/21/59
EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/23/59
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: DEC 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13961 — Reg. Dist. No. 13923

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 25 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1018 WOODSIDE PARKWAY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING
d. STREET ADDRESS: 1018 WOODSIDE PARKWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: HARRY — Middle: EDGAR — Last: NAU

4. DATE OF DEATH: Month: DEC. — Day: 29 — Year: 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: OCT. 25, 1889
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PLUMBING AND HEATING
10b. KIND OF BUSINESS OR INDUSTRY: Own business PLUMBING
11. BIRTHPLACE (State or foreign country): PA.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: GEORGE H. NAU
14. MOTHER'S MAIDEN NAME: EMMA K. STOUFFER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-07-9858
INFORMANT: AMES, MABEL E. — Address: 1018 WOODSIDE PKWY SILVER SPRING MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADENOCARCINOMA COLON WITH LIVER METASTASIS — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 YEARS
153.8
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from FEB 16, 1958, to DEC. 29, 1959, that I last saw the deceased alive on DECEMBER 29, 1959, and that death occurred at 2:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE James A. Roberts M.D. — **ADDRESS** (Street, city or town, state): 8907 GEORGIA AVENUE — **DATE SIGNED**: 12/29/59

PHYSICIAN'S NAME (Type): JAMES A. ROBERTS M.D. — SILVER SPRING, MARYLAND.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/31/59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Prince Geo. County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Zuka — **ADDRESS**: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE JAN 4 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1

13962

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13924

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital NNMC

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83x-3
d. STREET ADDRESS: 5605 19th ST North
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

051

3. NAME OF DECEASED (Type or print): First: Judith — Middle: Ann — Last: Nasipak

4. DATE OF DEATH: Month: December — Day: 13 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2 August 1955

9. AGE (In years lost birthday): 4 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Valentin Nasipak

14. MOTHER'S MAIDEN NAME: Shirley Oliver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: (Father) Valentin Nasipak — Address: Same as #2

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Wilms' Tumor, recurrent with metastases
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

180X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 13 December, 1959, to 13 December, 1959, that I last saw the deceased alive on 13 December, 1959, and that death occurred at 0840A M, from the causes and on the date stated above.

ACTUAL SIGNATURE H. L. Walton M.D.
ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda Md.
DATE SIGNED: 12-14-59

PHYSICIAN'S NAME (Type) H.L. Walton LT MC USN — U.S. Naval Hospital, Bethesda Md.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-17-59

22c. NAME OF CEMETERY OR CREMATORY: ST. Mary's

22d. LOCATION (City, town, or county) (State): Elyria, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R. A. HUMPHREY FUNERAL HOME BETHESDA, MD.
R. A. Humphrey

24a. REC'D BY REGISTRAR DATE DEC 16 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1

13963

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Montgomery Co — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring Md

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Althea Woodland Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: 2022 Klingle Rd. N.W. b. COUNTY: D. C.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 47X-3

d. STREET ADDRESS: ~~2001 Weaver St.~~

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First: CeCelia Middle: Last: Nelowich

4. DATE OF DEATH: Month: December Day: 27 Year: 1959 19

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 5-17-1887

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Julius Zeckerman

14. MOTHER'S MAIDEN NAME: Lena ~~Zeckerman~~ Light

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Gertrude Mensh Address: 2022 Klingle Rd., N.W.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 18 mo.

443X

DUE TO (b) Hypertensive cardio-vascular dis — 16 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from April, 1957, to Dec. 27, 1959 that I last saw the deceased alive on Dec. 24, 1959, and that death occurred at 12:20 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Armand B. Gordon, M.D. 2828-Conn. Ave, N.W.

PHYSICIAN'S NAME (Type): Armand B. Gordon, M.D. Wash. 8, D.C.

1

22a. BURIAL, ~~CREMATION, REMOVAL (Specify)~~: BURIAL

22b. DATE THEREOF: 12-29-59

22c. NAME OF CEMETERY OR CREMATORY: Adas Israel Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: B. Danzansky & Sons 3501 14th St., N.W.

24a. REC'D BY REGISTRAR DATE: DEC 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13926

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Bethesda
d. STREET ADDRESS: 5901 Aberdeen Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Judith; Middle: Vangrell; Last: Nelson

4. DATE OF DEATH: Month: 12; Day: 19; Year: 1959

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 11 1940

9. AGE (In years last birthday): 19 yrs.

IF UNDER 1 YEAR: Months: 6; Days:
IF UNDER 24 HRS.: Hours:; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: College

11. BIRTHPLACE (State or foreign country): D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alf Z. Nelson

14. MOTHER'S MAIDEN NAME: Ruth Mary Vogt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Father — Address: Alf Z Nelson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Exsanguination — INTERVAL BETWEEN ONSET AND DEATH: 2½ hrs.
DUE TO (b): Laceration & Rupture, Thoracic Aorta
DUE TO (c): Automobile Accident

825X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fractures of Rt Femur & Pelvis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Was passenger in car involved in auto accident

20c. TIME OF INJURY Month, Day, Year: Hour 7:00 a.m. p.m. 12-19 1959

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway

20f. (City or town): Bethesda (County): Monty (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Bresenan M.D.
EXAMINER'S NAME (Type): FRANK J. BRESENAN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-20-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-22-1959

22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

22d. LOCATION (City, town, or county) (State): Rockville Mont. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons — ADDRESS: Washington, D.C.

24a. REC'D BY REGISTRAR DATE: DEC 22 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13965

CERTIFICATE OF DEATH

13927
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville-Rural
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Matthews Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville-Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

094

3. NAME OF DECEASED (Type or print): First: Mary Middle: Newson Last: Winston
4. DATE OF DEATH: Month: December Day: 5 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: August 7-1869
9. AGE (In years last birthday): 90 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S
13. FATHER'S NAME: Dr Thomas Winston
14. MOTHER'S MAIDEN NAME: Caroline Mumford
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
INFORMANT: Mrs Hugh Beshers, Address: Poolesville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
170 X
DUE TO (b) Carcinomatosis generalized — 2 months
DUE TO (c) Carcinoma left breast — 5 months
Conditions, if any, which gave rise to immediate cause (a), stoting the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): advance arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1955, to Dec. 5, 1959, that I last saw the deceased alive on Dec. 4, 1959, and that death accurred at 1:30 P.M, from the causes and an the date stated above.

ACTUAL SIGNATURE: John Fawcett M.D. ADDRESS (Street, city or town, state): Dawsonville DATE SIGNED:
PHYSICIAN'S NAME (Type): JOHN G. FAWCETT P.O. Boyd, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 12/6/59
22c. NAME OF CEMETERY OR CREMATORY: ~~Oak Hill~~ Lee Funeral Home
22d. LOCATION (City, town, or county) (State): ~~Lawrence Kans.~~ Wash. D. C.
23. FUNERAL DIRECTOR'S SIGNATURE: William B Hilton, ADDRESS: Barnesville, Maryland
24a. REC'D BY REGISTRAR DATE: DEC 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13966

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13928

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookville
c. LENGTH OF STAY IN 1b: 18 yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brookville Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Brookville
d. STREET ADDRESS: Brookville Rd
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: Sarah; Last: Nicholson

4. DATE OF DEATH: Month: Dec; Day: 19; Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-20-1890
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel A Gover
14. MOTHER'S MAIDEN NAME: Rebecca Ayres

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Edward Nicholson — Address: Derwood R-1 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO
(b): hypertension — years
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rheumatic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-19-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 22 1959
22c. NAME OF CEMETERY OR CREMATORY: Laytonsville
22d. LOCATION (City, town, or county): Laytonsville (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W Barber — ADDRESS: Laytonsville, Md
24a. REC'D BY REGISTRAR — DATE: DEC 23 '59
24b. REGISTRAR'S SIGNATURE: Carroll S. [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13850

CERTIFICATE OF DEATH

Reg. Dist. No. 13929

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 6 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cedar Haven Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Va
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Arlington 83 x 3
d. STREET ADDRESS: 435 North Park Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eva Middle: E Last: Partello

4. DATE OF DEATH: Month: Dec Day: 30 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 23, 1873
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frederick Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Wiles
14. MOTHER'S MAIDEN NAME: Anne Wiles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: William C Jarvis Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage of bowel — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
153.8
DUE TO
(b) Carcinoma of bowel
DUE TO
(c) with metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 11, 1959, to Dec 30, 1959, that I last saw the deceased alive on Dec 30, 1959, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip E Jones M.D. ADDRESS (Street, city or town, state): 918 Ellsworth Drive DATE SIGNED:

PHYSICIAN'S NAME (Type): Philip E. Jones Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-4-60
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Del Funeral Home ADDRESS: Wash. DC
24a. REC'D BY REGISTRAR DATE JAN 4 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13860

CERTIFICATE OF DEATH

Reg. Dist. No. 13930

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 107 Aberdeen Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 2C Rockville
d. STREET ADDRESS: 107 Aberdeen Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OLIVER Middle H. Last PERRY

4. DATE OF DEATH: Month December Day 23, Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/28/'92
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months 2 Days 25 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Dealer
10b. KIND OF BUSINESS OR INDUSTRY: Automobiles
11. BIRTHPLACE (State or foreign country): Wash.,D.C.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Ulyssus G. Perry
14. MOTHER'S MAIDEN NAME: Clara D. Dean

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.:
INFORMANT: Dorothy M. Perry-Item# 2 Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour
420.1
DUE TO
(b) Arteriosclerosis — 15 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) Hypertension — 20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 1945, to 23 Dec, 1959, that I last saw the deceased alive on 23 Dec, 1959, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W S Murphy M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 12/24/59
PHYSICIAN'S NAME (Type): Wm. S. Murphy -W. Montg. Ave.,Rockville,Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/26/59
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or county) (State): Prince George Co.,Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home
ADDRESS: 1331 E. Montgomery Avenue,Rockville,Md.
24a. REC'D BY REGISTRAR DATE: DEC 28 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13967 13931

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 57 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 1615.2
d. STREET ADDRESS: 3813 Thornwood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert; Middle: Clarence; Last: PIERCE

4. DATE OF DEATH: Month: December; Day: 19; Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6-22-14

9. AGE (In years last birthday): 45 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Albert PIERCE

14. MOTHER'S MAIDEN NAME: Sarah CHAVES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: (Wife) Dorothy M. Pierce — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Retroperitoneal Liposcarcoma abdomen — INTERVAL BETWEEN ONSET AND DEATH: 7 years
197.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 23 October, 1959, to 19 December, 19 59 that I last saw the deceased alive on 19 December, 19 59, and that death occurred at 7:19P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Larry J. Hines M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda Md. — DATE SIGNED: 12-21-59

PHYSICIAN'S NAME (Type): L.J. HINES LCDR MC USN — U.S. Naval Hospital, Bethesda Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-23-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis J. Gasch — ADDRESS: Francis Gasch's 4739 Baltimore Ave. Hyattsville Md.

24a. REC'D BY REGISTRAR: DEC 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13968

Reg. Dist. No. 13932

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
Kensington Gardens Rest Home

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: D.C. b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3

d. STREET ADDRESS: 5236-44th.,St.,N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MABEL Middle I. Last PUGH

4. DATE OF DEATH: Month Dec., Day 12, Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 29, 1890
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Abner P.Parker
14. MOTHER'S MAIDEN NAME: ? Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Stanley S.Pugh Address: 5236-44th.,St.,N.W. Washington,D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 72 hours
334X
DUE TO
(b) Beside Generalized Arteriosclerosis
DUE TO
(c) Cerebral Sclerosis arteriolar

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Abdominal Tumor - Liver Enlargement

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) (County) (State) —

21. I certify that I attended the deceased from March, 1959, to 12-12, 1959, that I last saw the deceased alive on 12-12, 1959, and that death occurred at 1:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: P. P. Andrews M.D. M.D. ADDRESS (Street, city or town, state): 4201 Fessenden St N.W. Washington D.C. DATE SIGNED: 12-12-59

PHYSICIAN'S NAME (Type): P.P. ANDREWS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec.16,1959
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville Pike,Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Chevy Chase Funeral Home ADDRESS: 5703 Wisconsin Ave. Wash. DC
24a. REC'D BY REGISTRAR DATE: DEC 15 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 M 050 I 2 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13969 13933

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 205 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reading 75 x 3
d. STREET ADDRESS: 501 Funston Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kenneth — Middle: Robert — Last: Resch, Jr.

4. DATE OF DEATH: Month: December — Day: 30 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 1, 1954

9. AGE (In years last birthday): 5 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Kenneth R. Resch, Sr.

14. MOTHER'S MAIDEN NAME: Doris M. Kolewrecki

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Gastrointestinal Hemorrhage, Acute — INTERVAL BETWEEN ONSET AND DEATH
204.3
DUE TO
(b) Acute Leukemia — 6 Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 8, 1959, to December 30, 1959, that I last saw the deceased alive on December 30, 1959, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lawrence A. Gaydos M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 12-30-59
PHYSICIAN'S NAME (Type): LAWRENCE A. GAYDOS, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/31/59

22c. NAME OF CEMETERY OR CREMATORY: Lulenbach Cemetery

22d. LOCATION (City, town, or county) (State): Reading, Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR — DATE: JAN 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

Montgomery Pennsylvania

Bethesda 205 days Reading

The Clinical Center, Bethesda 14, Md. 201 Preston Avenue

Kenneth Robert Fesch, Jr. December 20 59

Male White October 1, 1958 5

Child None Pennsylvania U. S. A.

Kenneth R. Fesch, Sr. Doris M. Kolewrock
The Medical Record

No None The Clinical Center, Bethesda 14, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13970 — Reg. Dist. No. 13934

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: October 30, 1959
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens 3000 McComas Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: 4811 4th Street, Northwest — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47X-3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Hannah — Middle H — Last Robins
4. DATE OF DEATH: Month 12 — Day 10 — Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-13-1890
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): New York City, New York
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Alexander Eichwald
14. MOTHER'S MAIDEN NAME: Celia Feirstein
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
INFORMANT: Morris Robins (Husband) — Address: 4811 4th St. N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(b) Generalized Metastatic Carcinoma — 8-9 mos
DUE TO
(c) Carcinoma of Left Breast — 2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
170X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 10, 1957, to 12/10, 1959 that I last saw the deceased alive on 12/8, 1959, and that death occurred at 4:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold Stering — M.D. — ADDRESS (Street, city or town, state): 1352 University Blvd Hyattsville Md — DATE SIGNED: 12/10/59
PHYSICIAN'S NAME (Type): HAROLD STERING - M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: DEC. 13, 1959
22c. NAME OF CEMETERY ~~OR CREMATORY~~: BETHEL
22d. LOCATION (City, town, or county) (State): NEW YORK

23. FUNERAL DIRECTOR'S SIGNATURE: B. Dougherty & Sons — ADDRESS: 3501-14 Pa. Ave. Wash. D.C.
24a. REC'D BY REGISTRAR: DATE DEC 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13851

CERTIFICATE OF DEATH

Reg. Dist. No. 13935

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brandywine
d. STREET ADDRESS: Beechwood Farm
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

16X-2

3. NAME OF DECEASED (Type or print): First: Aquila; Middle: Turner; Last: Robinson

4. DATE OF DEATH: Month: 12; Day: 20; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-8-86

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Aquila T. Robinson

14. MOTHER'S MAIDEN NAME: Sally P. Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT: Hospital Records. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peptic Ulcer - hemorrhaging — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

540.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Dec 6, 1959, to Dec. 20, 1959, that I last saw the deceased alive on Dec. 19, 1959, and that death occurred at 12:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Hare, M.D. — ADDRESS (Street, city or town, state): Takoma Park, Md. — DATE SIGNED: 12/20/59

PHYSICIAN'S NAME (Type): Robert A. Hare M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-22-59

22c. NAME OF CEMETERY OR CREMATORY: St Pauls

22d. LOCATION (City, town, or county) (State): Waldorf, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hurtt Funeral Home, Waldorf Md — ADDRESS:

24a. REC'D BY REGISTRAR — DATE: DEC 23 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/5B

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13971 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Reg. Dist. No. 13936

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington

c. LENGTH OF STAY IN 1b: 1 mo

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10419 Mannakee St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: Montg

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington

d. STREET ADDRESS: 10419 Mannakee

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Nora Middle: Barry Last: Roche

4. DATE OF DEATH Month: Dec Day: 7 Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3-17-1882

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): dietitian

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Michael Barry

14. MOTHER'S MAIDEN NAME: Ellen Buckley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Jas. A. Roche Address: Silver

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I taak charge of the remains described abave, held an Autopsy ☐, Inspectian ☒, Inquiry ☒, and find that death resulted fram: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) FRANK J. BROSCHART

DATE SIGNED 12-7-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-10-59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

22d. LOCATION (City, town, or county) (State): Wash. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE Timothy Hanlon **ADDRESS** 3831-Ga. Ave N.W.

24a. REC'D BY REGISTRAR DATE DEC 18 59

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13972

CERTIFICATE OF DEATH

13937

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Parkerville
c. LENGTH OF STAY IN 1b: 18 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Parkerville ~~Rt~~
d. STREET ADDRESS: Route 28
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ALBERT Middle GARFIELD Last ROLFE

4. DATE OF DEATH: Month December Day 4 Year 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: JAN. 28, 1882
9. AGE (In years lost birthday): 77 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cattle farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY GEORGE ROLFE
14. MOTHER'S MAIDEN NAME: MARGARET BALDWIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1905
16. SOCIAL SECURITY NO.: 578 05 8934
INFORMANT: Marguerite R. Boggett
Address: Alexandria, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: Instantaneous
DUE TO
(b) 1st 2nd + 3rd degree heart block — 3 years.
DUE TO
(c) Arteriosclerotic heart disease — 3 years

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary edema.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work [ ] Not ~~while~~ at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 Feb, 1956, to Dec 4, 1958, that I last saw the deceased alive on December 2, 1959, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John G. Fawcett M.D. Dawsonville
ADDRESS (Street, city or town, state) — DATE SIGNED
PHYSICIAN'S NAME (Type): JOHN G. FAWCETT MD, P.O. BOYD MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): 1214
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
22d. LOCATION (City, town, or county) (State): Richmond, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Bliley Co. Inc.
ADDRESS: Richmond Va.
24a. REC'D BY REGISTRAR DATE: 12/4/59
24b. REGISTRAR'S SIGNATURE: William J. Hopkins MD

DEC 7 '59

Arthur S. Flemming

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13973

CERTIFICATE OF DEATH

Reg. Dist. No. 13938

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4025 Jones Bridge Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4025 Jones Bridge Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BLANCHE Middle S. Last ROUNDS

4. DATE OF DEATH: Month DEC. Day 18, Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 14, 1874
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months 0 Days 4
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (State or foreign country): Richford, Vermont
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Frank C. Sears
14. MOTHER'S MAIDEN NAME: Addie Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Mrs. Henry Bloom-daughter- Address: same as 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized arteriosclerosis and — INTERVAL BETWEEN ONSET AND DEATH: several years
450.0
DUE TO
(b) Congestive heart failure
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic bronchial asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 1948, 19____, to Dec 18, 1959, that I last saw the deceased alive on Dec. 18, 1959, and that death occurred at 6 30 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Saul Holtzman M.D.
ADDRESS (Street, city or town, state): 9000 17th Street, N. W.
DATE SIGNED: 12-19-59
PHYSICIAN'S NAME (Type): Saul Holtzman
Washington, D. C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 12/21/59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: DEC 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13852

CERTIFICATE OF DEATH

Reg. Dist. No. 13939

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 714 Albany Ave. Oak Haven Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Dist. of Col.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 47x-3
d. STREET ADDRESS: 2700 Connecticut Ave., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cyril Middle: Lawrence Last: Ryals

4. DATE OF DEATH Month: December Day: 17 Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 11-23-1886
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer- G.P.O.
10b. KIND OF BUSINESS OR INDUSTRY: Composition
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert Lawrence Ryals
14. MOTHER'S MAIDEN NAME: Judith Maria Lennan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes. (If yes, give war or dates of service): 1918-1919
16. SOCIAL SECURITY NO.: -------
INFORMANT: Mrs. Cecilia Ryals Address: (Sister)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
332x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis — ?
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Recent Diabetic Mellitus (one blood sugar shown)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1959, to Dec 17, 1959, that I last saw the deceased alive on Dec 11 1959, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas H Wolohan M.D. ADDRESS (Street, city or town, state): 7401 Blair Road NW Washington DC DATE SIGNED:
PHYSICIAN'S NAME (Type): CHAS H WOLOHAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-21-1959
22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl. Cemetery, Arlington, Va.
22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons, Inc. ADDRESS: 1756 Pa. Ave, Washington, D.C.
24a. REC'D BY REGISTRAR DATE: DEC 21 59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13974

CERTIFICATE OF DEATH

Reg. Dist. No. 13940

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 76 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newport News 83x-3
d. STREET ADDRESS: 502 Hickory Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First: William — Middle: (None) — Last: Sacker

4. DATE OF DEATH: Month: December — Day: 6 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 25, 1898
9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchandise Manager
10b. KIND OF BUSINESS OR INDUSTRY: Department Store
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Max Sacker
14. MOTHER'S MAIDEN NAME: Anna Kleinhouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 223-09-3569
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
200.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute Leukemia
DUE TO
(c) Reticulum Cell Sarcoma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 21 1959, to December 6, 1959, that I last saw the deceased alive on December 6, 1959, and that death occurred at 5:40A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur R. Rothman M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 12-6-59
PHYSICIAN'S NAME (Type): ARTHUR R. ROTHMAN, M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12-8-59
22c. NAME OF CEMETERY OR CREMATORY: --
22d. LOCATION (City, town, or county) (State): Cleveland Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: B Danganski & Sons — ADDRESS: 3501-14th St N W
24a. REC'D BY REGISTRAR: DATE DEC 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13975

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13941

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4602 Chase Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4602 Chase Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWIN — Middle JOHN — Last SACKETT

4. DATE OF DEATH: Month Dec. — Day 5 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 28, 1896

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months 2 — Days 7
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10b. KIND OF BUSINESS OR INDUSTRY: Chief

11. BIRTHPLACE (State or foreign country): New York City, N.Y.

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Maurice Sackett

14. MOTHER'S MAIDEN NAME: Lillian Beaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Yes-Unknown

17. INFORMANT: Wife — Address: Ethel A. Sackett — Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
420.1
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Found dead on bedroom floor

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. 19

20d. INJURY OCCURRED While of work ☐ Not while of work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12/5/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-9-59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Prince George Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE DEC 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13976 Reg. Dist. No. 13942

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 13 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8708 Colesville Rd.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 5 Silver Spring
d. STREET ADDRESS: 8708 Colesville Rd Apt 203
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Simon Middle: Sandler Last:
4. DATE OF DEATH: Month: Dec Day: 21 Year: 1959

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr. 16 1908
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Architect Eng.
10b. KIND OF BUSINESS OR INDUSTRY: Dept of Army
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ben Sandler
14. MOTHER'S MAIDEN NAME: Fannie Resnick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Rose Ruth Sandler Address: Stein 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-21-59
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/22/59
22c. NAME OF CEMETERY OR CREMATORY: Ansche Emunah
22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Sol Levinson & Bros Inc
ADDRESS: 1124-26 W. North Ave.
24a. REC'D BY REGISTRAR DATE DEC 23 '59
24b. REGISTRAR'S SIGNATURE: Clifton S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13977

CERTIFICATE OF DEATH

Reg. Dist. No. 13943

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 3216 Reservoir Road, N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: (None); Last: Sawyer
4. DATE OF DEATH: Month: December; Day: 17; Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 16, 1891
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nutritionist
10b. KIND OF BUSINESS OR INDUSTRY: Red Cross
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13. FATHER'S NAME: Albert B. Sawyer
14. MOTHER'S MAIDEN NAME: Fannie Wardall
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unascertainable
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Carcinoma of the breast — 2 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 14, 1959, to December 17, 1959, that I last saw the deceased alive on December 17, 1959, and that death occurred at 5:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard C Mechanic M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 12/18/59
PHYSICIAN'S NAME (Type): Richard C. Mechanic M.D.

22a. ~~BURIAL~~, CREMATION, ~~REMOVAL~~ (Specify): Cremation
22b. DATE THEREOF: Dec. 19, 1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, P. G., Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons — ADDRESS: WASH. D.C.
24a. REC'D BY REGISTRAR: DATE DEC 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re[redacted] by the hospital or attending physician.
TO FUNERAL [redacted]RECTOR: After this certificate has been signed by the attending physician and completely filled in [redacted] the funeral director, page 3 shou[redacted] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13978

CERTIFICATE OF DEATH

13944

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7100 Ridgewood Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 7100 Ridgewood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joy; Middle: M; Last: Schmitt
4. DATE OF DEATH: Month: Dec.; Day: 6; Year: 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/28/1888
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months: 5; Days: 8 — IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Washington D. C.
12. CITIZEN OF WHAT COUNTRY?: U. S.
13. FATHER'S NAME: Alfred P. Marston
14. MOTHER'S MAIDEN NAME: Alice A. Sullivan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Edwin A. Schmitt-husband-same as 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes
162.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Bronchogenic carcinoma of left lung — 1 year
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year 19; Hour o. m. p. m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 26, 19 58, to December 6, 19 59, that I last saw the deceased alive on December 4, 1959, and that death occurred at 11:10 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert G. Angle M.D. — ADDRESS (Street, city or town, state): 5009 Del Ray Ave., Bethesda, Md. — DATE SIGNED: 12/6/59

PHYSICIAN'S NAME (Type): Robert G. Angle, M.D. 5009 Del Ray Ave., Bethesda, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/9/59
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE DEC 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Norris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13979

Reg. Dist. No. 13945

1. PLACE OF DEATH a. COUNTY: MONTGOMERY MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA

c. LENGTH OF STAY IN 1b: 15 yr

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ROSINE Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: MONTGOMERY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE

d. STREET ADDRESS: 6804 Georgia

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First ELISE Middle Last SCHOMACKER

4. DATE OF DEATH Month DEC Day 23 Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH 17 Nov. 1871 CALIFORNIA

9. AGE (In years lost birthday) 88 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): CALIFORNIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John SAMBS

14. MOTHER'S MAIDEN NAME: HELENE ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: F. C. MOCKALL Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. — INTERVAL BETWEEN ONSET AND DEATH

331X

DUE TO (b) CEREBRAL ARTERIOSCLEROSIS — 5-

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1959, to Dec 23, 1959, that I last saw the deceased alive on Nov, 1959, and that death occurred at 11 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): W. H. Killax DATE SIGNED: 23 Dec 59

PHYSICIAN'S NAME (Type): W H Killax

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 12-26-59

22c. NAME OF CEMETERY OR CREMATORY: Tees Crematory

22d. LOCATION (City, town, or county) (State): Wash. D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Wm. Lee Sons — Wash. DC ADDRESS

24a. REC'D BY REGISTRAR DATE DEC 29 '59

24b. REGISTRAR'S SIGNATURE: Clarence S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be r[illegible]d by the hospital or attending physician.

TO FUNER[illegible]RECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1.

Scott 13980

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney SANDY SPRING

c. LENGTH OF STAY IN 1b: 8 hrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY COUNTY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 ROCKVILLE

d. STREET ADDRESS: 1 4105 BEVERLY ROAD

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

073

3. NAME OF DECEASED (Type or print): First EUGENE Middle WILEY Last SCOTT

4. DATE OF DEATH: Month DEC. Day 4 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/17/86

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Entomologist

10b. KIND OF BUSINESS OR INDUSTRY: Dept. of Agriculture U. S. Gov't.

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LEVY M. SCOTT

14. MOTHER'S MAIDEN NAME: AMANDA EDMONDSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW #1

16. SOCIAL SECURITY NO.: none

INFORMANT: Mrs. Betsy H. Scott, Address: 4105 Beverly Rd. Rockville, Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Apoplexia Thrombotica — INTERVAL BETWEEN ONSET AND DEATH: 8 hr

260X

DUE TO (b) Diabetes Mellitus — 5 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Hypertensive cardiovascular disease — 12 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1959, to Dec, 1959, that I last saw the deceased alive on Dec 4, 1959, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bonifaht M.D. ADDRESS (Street, city or town, state): Sandy Spring, Md. DATE SIGNED: 12/4/59

PHYSICIAN'S NAME (Type): H. D. BONIFAHT

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12/7/59

22c. NAME OF CEMETERY OR CREMATORY: ROCKVILLE CEMETERY

22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zurka WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: DEC 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13853

13947

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47X-3
d. STREET ADDRESS: 7444 Georgia Ave. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Frances; Middle: Lucine; Last: Seilenspinner

4. DATE OF DEATH: Month: 12; Day: 2; Year: 1959

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 1-5-07
9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales lady
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Johnson
14. MOTHER'S MAIDEN NAME: Mary Bell Ferrin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-05-9614
INFORMANT: Washington Sanitarium + Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: about 1/2 months
171X
DUE TO
(b): Carcinoma of Cervix — about 1 1/2 year
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1959, to December 2, 1959, that I last saw the deceased alive on December 1, 1959, and that death occurred at 7:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Benjamin Isaacson M.D. — ADDRESS (Street, city or town, state): 7733 Alaska Ave. N.W. Wash. 12 D.C. — DATE SIGNED: 12/2/59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 12/4/59
22c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: John W. McCauley — ADDRESS: 2401-14th St. N.W. — The S.H. Hines Co. by Washington, D.C.
24a. REC'D BY REGISTRAR: DATE DEC 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re[illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13948

13981

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

050

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 85 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia b. COUNTY: Alexandria
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 83x-3
d. STREET ADDRESS: 3224 Martha Curtis Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward Middle: (No middle name) Last: Siff
4. DATE OF DEATH: Month: December Day: 18 Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4 January 1914
9. AGE (In years last birthday): 45 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgt. Analyst
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Simon L. Siff
14. MOTHER'S MAIDEN NAME: Lena Levin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: None
INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia and Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

190.9

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Perforation of Stomach — 5 days

DUE TO

(c) Malignant Lymphoma — 3½ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 24, 19 59, to December 18, 19 59 that I last saw the deceased alive on December 18, 19 59, and that death occurred at 7:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Norman R. Gevirtz M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 12/18/59
PHYSICIAN'S NAME (Type): NORMAN R. GEVIRTZ, M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-20-59
22c. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship
22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Jack Lewis Inc. ADDRESS: 2100 Eutaw Place
24a. REC'D BY REGISTRAR DATE: DEC 22 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A1S (4)
1SM 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13854 — Reg. Dist. No. 13949

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 6 hrs. 55 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 206 Indian Spring Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: (None) — Last: Smackey
4. DATE OF DEATH: Month: 12 — Day: 20 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-18-1882
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY: (Ret.)
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: Address: Washington Sanitarium + Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 hours
900.0
DUE TO (b): Contusions and lacerations
DUE TO (c): A fall down stairs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Reported to have fallen down stairs at home
20c. TIME OF INJURY: Hour 1:15 a. m. — Month, Day, Year: 12-20 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Silver Spring (County): Montg. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 12-20-59
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/21/59
22c. NAME OF CEMETERY OR CREMATORY: MONTIFIORE CEM.
22d. LOCATION (City, town, or county) (State): SPRINGFIELD GARDENS, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE: Dealey Funeral Home — ADDRESS: 4217-9th Ave
24a. REC'D BY REGISTRAR: DATE DEC 23 '59
24b. REGISTRAR'S SIGNATURE: Catherine S. [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13861

CERTIFICATE OF DEATH

Reg. Dist. No. 13950

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2 W. Argyle Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Rockville
d. STREET ADDRESS: 2 W. Argyle Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSE Middle E. Last SMITH

4. DATE OF DEATH: Month Dec. Day 31, Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/8/1873
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Charles W. Forsyth
14. MOTHER'S MAIDEN NAME: Mary F. Utterback

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Mrs Wm. V. Robertson — Address: Item#2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week
002X
DUE TO
(b) Far advanced active pulmonary tuberculosis — 10 years
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1950, 19__, to Dec. 31, 1959 that I last saw the deceased alive on Dec. 25, 1959, and that death occurred at 7 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm A. Linthicum M.D. — ADDRESS (Street, city or town, state): 110 S. Washington St. — DATE SIGNED: 12/31/59

PHYSICIAN'S NAME (Type): Wm. A. Linthicum Rockville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/2/60
22c. NAME OF CEMETERY OR CREMATORY: Rockville
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler — ADDRESS: Funeral Home -Rockville. Md
24a. REC'D BY REGISTRAR DATE JAN 4 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13982

Reg. Dist. No. 13951

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 19 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 5928 9th.St N.W. Apt. # 22
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: F — Last: Smoot
4. DATE OF DEATH: Month: Dec. — Day: 31 — Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/11/95
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman Painter
10b. KIND OF BUSINESS OR INDUSTRY: Dept. of Agriculture
11. BIRTHPLACE (State or foreign country): WASH. D.C
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: FRANK P. SMOOT
14. MOTHER'S MAIDEN NAME: MARY BEECHAM.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): ARMY
16. SOCIAL SECURITY NO.: 578-18-2023
INFORMANT: Margaret B. Smoot — Address: above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12-11-59
420.0
DUE TO (b): arteriosclerotic heart disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Sept 15-59 - Coronary insufficiency with occlusion
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 9-15, 1959, to 12-31, 1959 that I last saw the deceased alive on 12-31, 1959, and that death occurred at 9 40 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E Nolan M.D. — ADDRESS (Street, city or town, state): 5401 Western Ave N W — DATE SIGNED:
PHYSICIAN'S NAME (Type): JAMES E. NOLAN — Washington, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/5/60
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Malley's Funeral Home Inc. — ADDRESS: Mt. Rainier Md.
24a. REC'D BY REGISTRAR — DATE: JAN 5 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13983

CERTIFICATE OF DEATH

Reg. Dist. No. 13952

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 75 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New York
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baldwin, Long Island 69 X-3
d. STREET ADDRESS: 1832 Longfellow Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First Janet — Middle Mary — Last Spinrad
4. DATE OF DEATH: Month December — Day 27 — Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 16, 1912
9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Litho-Stripper
10b. KIND OF BUSINESS OR INDUSTRY: Printing
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Ralph E. Cole
14. MOTHER'S MAIDEN NAME: Frances Walker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unascertainable
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		Interval between onset and death
IMMEDIATE CAUSE (a)	respiratory failure	minutes
DUE TO (b)	tracheobronchitis with mucous obstruction and bilateral pleural effusion	months
DUE TO (c)	metastatic carcinoma from the left breast	months

170 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 13, 1959, to December 27, 1959, that I last saw the deceased alive on December 27, 1959, and that death occurred at 2:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard C Mechanic M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: December 28, 1959
PHYSICIAN'S NAME (Type): RICHARD C. MECHANIC, M. D.

1

22a. ~~BURIAL~~, CREMATION, ~~REMOVAL~~ (Specify): 12/28/59
22b. DATE THEREOF
22c. ~~NAME OF CEMETERY~~ OR CREMATORY: Fresh Pond Crematory
22d. LOCATION (City, town, or county) (State): Queens County New York

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
7557 Wisconsin Ave Bethesda, Md
24a. REC'D BY REGISTRAR DATE: DEC 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13984

CERTIFICATE OF DEATH

Reg. Dist. No. 13953

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 34 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills, 02X-2
d. STREET ADDRESS: Box 368
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First: George; Middle: William; Last: Sterling

4. DATE OF DEATH: Month: December; Day: 31; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 22, 1896

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Machinery

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: George W. Sterling

14. MOTHER'S MAIDEN NAME: Clara Lott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578-09-9303

INFORMANT: The Medical Record
Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhagic Pneumonitis, Right Lung, secondary to Monilia. — INTERVAL BETWEEN ONSET AND DEATH: 1 Week
204.3
DUE TO
(b) Acute Myelogenous Leukemia. — 2 Months
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 27, 1959, to December 31, 1959, that I last saw the deceased alive on December 31, 1959, and that death occurred at 7:35 pM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold J. Fallon, M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 1/1/60

PHYSICIAN'S NAME (Type): HAROLD J. FALLON, M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 4, 1960

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Hopping Funeral Home, Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: JAN 5 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13985 Reg. Dist. No. 13954

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Gaithersburg
d. STREET ADDRESS: 212 Brooks Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arnold Middle: Raymond Last: Stull
4. DATE OF DEATH: Month: 12/21/59 Day: Year: 19
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/25/1901
9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Ulysses Stull
14. MOTHER'S MAIDEN NAME: Mary J. Kaiser
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Stull (wife) Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History if previous coronary desease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED: 12/21/59
EXAMINER'S NAME (Type): Frank J, Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-21-59
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak
22d. LOCATION (City, town, or county) (State): Gaithersburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: 316 E Diamond Ave Gaithersburg, Md.
24a. REC'D BY REGISTRAR DATE DEC 22 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13855

CERTIFICATE OF DEATH

Reg. Dist. No. 13955

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring Md.
d. STREET ADDRESS: 9216 Longbranch Pkwy.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GORDON Middle K Last SUTHARD, JR. — Baby Boy.
4. DATE OF DEATH: Month DEC Day 31 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/30/59
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours 12 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gordon Keith Suthard
14. MOTHER'S MAIDEN NAME: Isabelle Agnes LeTourneau

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
INFORMANT: Mother's Hospital Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia - Pallida — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

762.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DIFFICULT DELIVERY AT BIRTH
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Dec 30, 1959, to Dec 31, 1959, that I last saw the deceased alive on Dec 30, 1959, and that death occurred at 12:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George B. Spence M.D. — ADDRESS (Street, city or town, state): 1515 HIGHLAND DRIVE SILVER SPRING MD — DATE SIGNED:

PHYSICIAN'S NAME (Type): GEORGE B. SPENCE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1/2/60
22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.
Raymond A. Zeska
24a. REC'D BY REGISTRAR DATE JAN 4 '60
24b. REGISTRAR'S SIGNATURE: Cathrine S. Krome

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

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2

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13986

CERTIFICATE OF DEATH

Reg. Dist. No. 13956

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 11515 Kenton Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Orville; Middle: Franklin; Last: Taylor

4. DATE OF DEATH: Month: December; Day: 13; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 26 April 1921

9. AGE (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repairman

10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Taylor

14. MOTHER'S MAIDEN NAME: Minnie Trader

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 330-05-5948

INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
163X
DUE TO
(b) Epidermoid Carcinoma, Lung — 18 Months
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 23, 1959, to December 13, 1959 that I last saw the deceased alive on December 13, 1959, and that death occurred at 10:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles E. Mengel M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 12-13-59
PHYSICIAN'S NAME (Type): CHARLES E. MENGEL, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 12/16/59
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Montgomery County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co.
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.

24a. REC'D BY REGISTRAR DATE: DEC 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [redacted] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13856

CERTIFICATE OF DEATH

13957

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium and Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 14 Cleveland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

075

3. NAME OF DECEASED (Type or print): First: Ella — Middle: Sophia — Last: Terrill
4. DATE OF DEATH: Month: Dec — Day: 11 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7-10-72
9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home work
11. BIRTHPLACE (State or foreign country): W. Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Louis Baumann
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Florence L. Terrill — Address: Long Island - N.Y.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage - Left Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
331X
DUE TO
(b) Senile Arteriosclerosis — 10 years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 Dec, 1959, to 11 Dec, 1959, that I last saw the deceased alive on 10 Dec, 1959, and that death occurred at 1:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H B Queen M.D. — ADDRESS (Street, city or town, state): 7112 Willow Ave — DATE SIGNED: 11 Dec 1959
PHYSICIAN'S NAME (Type): H. B. QUEEN — TAKOMA PARK

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec-14-1959
22c. NAME OF CEMETERY OR CREMATORY: Pine Grove Cemetery
22d. LOCATION (City, town, or county) (State): Elm Grove Fort Vergenne
23. FUNERAL DIRECTOR'S SIGNATURE: Arthur Walters — ADDRESS: 254 Carroll St N.W.
24a. RECEIVED BY REGISTRAR — DATE: DEC 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

N6

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13987

CERTIFICATE OF DEATH

Reg. Dist. No. 215 13958

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051

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2

1

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural) — c. LENGTH OF STAY IN 1b: 37 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Monroe 83 x - 3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda Md.	d. STREET ADDRESS: 311 B Fenwick Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Edward	D	THIEBAUD		December	20	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White		11-7-57	2 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Germany	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles J. THIEBAUD	Herta WARTGEG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT	Address
No		None	(Father) Charles J. Thiebaud	Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) NEUROBLASTOMA
193.4
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m. — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 13 November, 1959, to 20 December, 1959, that I last saw the deceased alive on 20 December, 1959, and that death occurred at 11:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Fred W Grello M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda Md. — DATE SIGNED: 12-21-59

PHYSICIAN'S NAME (Type) F.W. GRELLO LT MC USN — U.S. Naval Hospital, Bethesda Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12-24-59	National Hampton Cemetery	Hampton Va.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
R. Hayden Smith 245 Armistead Ave. Hampton Va.	DEC 28 '59	Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [redacted]ed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13988 Reg. Dist. No. 13959

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney, Md.
c. LENGTH OF STAY IN 1b: 7 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery Co. Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sandy Spring, Md.
d. STREET ADDRESS: Chandlee Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

073

3. NAME OF DECEASED (Type or print): First: Malchia Middle: Last: Thomas
4. DATE OF DEATH: Month: 12 Day: 17 Year: 1959
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/6/14
9. AGE (In years last birthday): 45 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Clifton Edward Thomas
14. MOTHER'S MAIDEN NAME: Mary Mamie Simpson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock — INTERVAL BETWEEN ONSET AND DEATH: 7½ hrs.
916.0
DUE TO (b) 1st, 2nd and 3rd degree burns involving head, trunk and extremities.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) burning of house.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burning of home.
20c. TIME OF INJURY: Hour 9:20 a.m. p.m. Month, Day, Year 12 16 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town) (County) (State): Sandy Spring, Montg. Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12.17.59
EXAMINER'S NAME (Type): Frank J. Broschart,

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/20/59
22c. NAME OF CEMETERY OR CREMATORY: Ash Memorial
22d. LOCATION (City, town, or county) (State): Sandy Spring, Md
23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden ADDRESS: Rockville, Md
24a. REC'D BY REGISTRAR DATE: DEC 22 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13989 Reg. Dist. No. 13960

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Kensington Gardens Sanitarium, 3000 McComas Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47X-3
d. STREET ADDRESS: 4919 SEDGWICK ST., N.W.
e. WAS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First John Middle W Last Thompson

4. DATE OF DEATH: Month 12 Day 4 Year 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3/9/1892

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: GOV'T.

11. BIRTHPLACE (State or foreign country): WASH., D.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ROSS THOMPSON

14. MOTHER'S MAIDEN NAME: WENA DeBRULER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WORLD WAR I

16. SOCIAL SECURITY NO.: 577-03-1023

INFORMANT: IMOGEN THOMPSON, Address: 4919 SEDGWICK ST., N.W. WASHINGTON, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, right lung. — INTERVAL BETWEEN ONSET AND DEATH: 36 hours.
493X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 1. Anemia 2. Congestive heart failure. 3. Parkinson's disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept., 1958, to 4 December, 1959, that I last saw the deceased alive on 3 December, 1959, and that death occurred at 10:08 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Seruch T. Kimble M.D. — **ADDRESS** (Street, city or town, state): 929 Pershing Drive, Silver Spring, Maryland — **DATE SIGNED**: 4 Dec., 1959.

PHYSICIAN'S NAME (Type): SERUCH T. KIMBLE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12/8/59

22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEM.

22d. LOCATION (City, town, or county) (State): FORT MYER, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons — **ADDRESS**: 1756 PA. AVE., N.W. DC

24a. REC'D BY REGISTRAR DATE DEC 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13990

13961

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital NNMC

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Vienna 83 x-3
d. STREET ADDRESS: RT#3 Box 490
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

051

3. NAME OF DECEASED (Type or print): First: Rose; Middle: Yeary; Last: THOMPSON

4. DATE OF DEATH: Month: December; Day: 12; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 7 30 82

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Thomas Yeary

14. MOTHER'S MAIDEN NAME: Alice CRABTREE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: (Son) Robert THOMPSON — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma Rectum c mets to lungs — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
154X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 25 November, 1959, to 12 December, 1959, that I last saw the deceased alive on 12 December, 1959, and that death occurred at 4:55 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) — DATE SIGNED

ACTUAL SIGNATURE: B.C. Johnson M.D.

PHYSICIAN'S NAME (Type): B.C. Johnson LCDR MC USN U.S. NAVAL HOSPITAL Bethesda, Md.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-15-59

22c. NAME OF CEMETERY OR CREMATORY: Cecil Cemetery

22d. LOCATION (City, town, or county) (State): Vienna, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Tyson Wheeler Funeral Home Rockville, Md.

24a. REC'D BY REGISTRAR DATE DEC 16 '59

24b. REGISTRAR'S SIGNATURE: Adam S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13991

CERTIFICATE OF DEATH

13962

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 41 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: District of Columbia — b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47 x-3

d. STREET ADDRESS: 2318 - 16th Street, S.E.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frederick — Middle: (None) — Last: Trossbach

4. DATE OF DEATH: Month: December — Day: 24 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4 July 1890

9. AGE (In years lost birthday): 69 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Phillip Trossbach

14. MOTHER'S MAIDEN NAME: Lucy Romeise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-14-3427

INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

154X

DUE TO (b) Arteriolar Nephrosclerosis — ? years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Carcinoma of the Rectum — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Metastatic Carcinoma in Liver, Myocardial Hypertrophy, Atherosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 13, 1959, to December 24, 1959 that I last saw the deceased alive on December 24, 1959, and that death occurred at 11:05 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Alan B. Retik M.D. — **ADDRESS** (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — **DATE SIGNED**: 12/25/59

PHYSICIAN'S NAME (Type): ALAN B. RETIK, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/28/59

22c. NAME OF CEMETERY OR CREMATORY: St. Michaels

22d. LOCATION (City, town, or county) (State): Ridge, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — **ADDRESS**: P.B. Robinson - Leonardtown, Md.

24a. REC'D BY REGISTRAR DATE DEC 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13992 Reg. Dist. No. 13963

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 21 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9010 Seneca Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 9010 Seneca Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: D Last: Urry
4. DATE OF DEATH Month: December Day: 16 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: May 1, 1905
9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months: 7 Days: 15 IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Scientist
10b. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Albert Urry
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Greta Urry-wife-same as 2d Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 15 min.

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: John G. Ball M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED: 16 Dec 1959
EXAMINER'S NAME (Type): John G. Ball

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/19/59
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: DEC 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13993

CERTIFICATE OF DEATH

Reg. Dist. No. 13964

1. PLACE OF DEATH
a. COUNTY: Montg — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 7Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montg, Co, General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Gaithersburg
d. STREET ADDRESS: 111 Walker Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

073

3. NAME OF DECEASED (Type or print): First: Marshall — Middle: Murray — Last: Walker

4. DATE OF DEATH: Month: Dec — Day: 17 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct 19-1880

9. AGE (In years lost birthday): 79 yrs. — IF UNDER 1 YEAR: Months: 1 — Days: 28 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retail Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Retail Grocery

11. BIRTHPLACE (State or foreign country): Gaithersburg Md,

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: George E. Walker

14. MOTHER'S MAIDEN NAME: Ella S. Miles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Minnie B. Walker. — Address: 11 Walker Ave Gaithersburg. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage, Retroperitoneal, — INTERVAL BETWEEN ONSET AND DEATH: 20 hours
DUE TO (b) due to rupture abdominal aorta.
451X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Atherosclerosis — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1953, 19____, to Dec. 17, 1959, that I last saw the deceased alive on Dec. 18, 1959, and that death occurred at 2:15 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Jack Schumacher, M.D. — ADDRESS (Street, city or town, state): 105 Russell Ave., Gaithersburg, Md. — DATE SIGNED: 12-18-59

PHYSICIAN'S NAME (Type): Jack Schumacher

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-19-59

22c. NAME OF CEMETERY OR CREMATORY: Forest Oak

22d. LOCATION (City, town, or county) (State): Gaithersburg. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Arthur — ADDRESS: Gaithersburg Md.

24a. REC'D BY REGISTRAR DATE: DEC 21 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1 X.

M

074

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13994

Reg. Dist. No. 13965

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3½ days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville 26
d. STREET ADDRESS: 308 Grosnther
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EOLIA Middle Ann Last Ward

4. DATE OF DEATH: Month 12 Day 3 Year 1959

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 23, 1876
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wash. D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: — Huthum
14. MOTHER'S MAIDEN NAME: Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
INFORMANT: Paul E. Wardell, 308 Grosnther — Address: Rockville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombus — INTERVAL BETWEEN ONSET AND DEATH: 4 days
332 X
DUE TO
(b) Arteriosclerosis — 30 years
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 1958, to 3 Dec, 1959, that I last saw the deceased alive on 3 Dec, 1959, and that death occurred at 8:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W S Murphy M.D. — ADDRESS (Street, city or town, state): 615 Montgomery Ave, Rockville Maryland — DATE SIGNED: 3 Dec 59

PHYSICIAN'S NAME (Type): W. S. MURPHY

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/5/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Malley's Funeral Home Inc. — ADDRESS: Mt. Rainier, Md.
24a. REC'D BY REGISTRAR: DATE DEC 7 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

1.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13995

CERTIFICATE OF DEATH

13966

Reg. Dist. No. 215

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda Md.

051

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cobb Island — 08X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wanda — Middle: Deane — Last: WARREN
4. DATE OF DEATH: Month: December — Day: 4 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-13-16
9. AGE (In years last birthday): 43 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Horace Edwards
14. MOTHER'S MAIDEN NAME: Zell M. JOHNSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: (Husband) James L. Warren — Address: Same as #2

1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intestinal obstruction + electrolyte imbalance — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b) Laennec's cirrhosis — 1 year
DUE TO
(c)

581.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 November, 1959, to 4 December, 1959, that I last saw the deceased alive on 4 December, 1959, and that death occurred at 6:55A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. G. Muth, M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda Md — DATE SIGNED: 12-4-59

PHYSICIAN'S NAME (Type): R.G. MUTH LT MC USN — U.S. Naval Hospital, NNMC, Bethesda Md.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-8-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE: R.A. Pumphrey Funeral Dirs. Inc.
ADDRESS: R.A. Pumphrey 7557 Wisconsin Ave. Bethesda Md.
24a. REC'D BY REGISTRAR: DATE DEC 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13996

CERTIFICATE OF DEATH

13967
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 39 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia b. COUNTY: King George

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): King George 83x-3

d. STREET ADDRESS: Route #2, Box 68

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First: Henry Middle: George Last: Wegner

4. DATE OF DEATH Month: December Day: 28 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11 January 1897

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Public works inspector

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul L. Wegner

14. MOTHER'S MAIDEN NAME: Matilda Roesky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: UNASCERTAINABLE

INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

I

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) thrombosis of thoracic and abdominal aorta

451x

DUE TO

(b) generalized severe arteriosclerosis

DUE TO

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): malignant lymphoma: skin, lymph nodes, spleen, kidney, liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from November 19, 1959, to December 28, 1959 that I last saw the deceased alive on December 28, 1959, and that death occurred at 5:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard C Mechanic M.D.

ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Maryland

DATE SIGNED: December 28, 1959

PHYSICIAN'S NAME (Type): RICHARD C. MECHANIC, M. D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/31/1959

22c. NAME OF CEMETERY OR CREMATORY: Oakland

22d. LOCATION (City, town, or county) (State): Owens, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Nash & Slaw by James Bryan Jr. ADDRESS: Ninde, Virginia

24a. REC'D BY REGISTRAR DATE: DEC 31 '59

24b. REGISTRAR'S SIGNATURE: Arthur S Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13997

Reg. Dist. No. 13968

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7611 Whittier Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 7611 Whittier Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IDA Middle: BELLE Last: WELLS

4. DATE OF DEATH: Month: Dec. Day: 30, Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 21, 1872

9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months 6 Days 9 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --------

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Charles Storrin

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT: Robert A. Wells-son-same as 2d — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS, LEFT — INTERVAL BETWEEN ONSET AND DEATH: 14 HRS.
332X
DUE TO
(b) ARTERIOSCLEROSIS, GENERAL — 5 YRS.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from JUNE, 1958, to DEC. 30, 1959, that I last saw the deceased alive on DEC. 30, 1959, and that death occurred at 8:15 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo M. Curtis M.D. ADDRESS (Street, city or town, state): 8218 Wisconsin Ave. DATE SIGNED: Bethesda, Maryland 12-31-59

PHYSICIAN'S NAME (Type): LEO M. CURTIS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/2/60

22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: JAN 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13998

Reg. Dist. No. 13969

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3113 Ferndale Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4218 Matthews Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pauline; Middle: A; Last: Wighington

4. DATE OF DEATH: Month: Dec.; Day: 29; Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 25, 1920
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months 3, Days 4
IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Paul V. Reardon
14. MOTHER'S MAIDEN NAME: Minnie I. Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
INFORMANT: Victor E. Wighington, Jr.-Husband-
Address: same as 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 18 HRS.
195.0
DUE TO
(b) HEPATIC METASTASES — 3 MOS
DUE TO
(c) CARCINOMA, RIGHT ADRENAL GLAND — 9 MOS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/11/, 1959, to 12/29, 1959, that I last saw the deceased alive on 12/29/, 1959, and that death occurred at 7:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Tuohy M.D.
ADDRESS (Street, city or town, state): 7720 WISCONSIN AVE BETHESDA 14, MD.
DATE SIGNED: 12/29/59
PHYSICIAN'S NAME (Type): John H. Tuohy 7720 Wisc. Ave. Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/4/60
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: JAN 4 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13999

CERTIFICATE OF DEATH

13970

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 30 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83X-3
d. STREET ADDRESS: 5868 South 1st Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First: Jerry; Middle: Lee; Last: Williams

4. DATE OF DEATH: Month: December; Day: 6; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: January 28, 1940

9. AGE (In years last birthday): 19 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Food Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Grocery

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Iradell David Williams

14. MOTHER'S MAIDEN NAME: Dolores Cornelia George

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 403-50-5513

INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
204.1
DUE TO (b) Acute Pulmonary Edema
DUE TO (c) Acute Myelogenous Leukemia with massive enlargement of spleen, liver, lymph nodes and kidneys — 9 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 6, 1959, to December 6, 1959 that I last saw the deceased alive on December 6, 1959, and that death occurred at 2:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur R Rothman M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 12/6/59

PHYSICIAN'S NAME (Type): Arthur R. Rothman M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): TRANSITORY BURIAL
22b. DATE THEREOF: 12-8-59
22c. NAME OF CEMETERY ~~OR CREMATORY~~: MT. KENTON
22d. LOCATION (City, town, or county) (State): PADUCAH, KY

23. FUNERAL DIRECTOR'S SIGNATURE: C. P. Dreamer
ADDRESS: ARLINGTON, VA

24a. REC'D BY REGISTRAR DATE: DEC 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14000

CERTIFICATE OF DEATH

Reg. Dist. No. 13971

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Resmor Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3724 Cumberland St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

090

3. NAME OF DECEASED (Type or print): First: JOHN — Middle: FRANCIS — Last: WILLIAMS

4. DATE OF DEATH: Month: Dec. — Day: 11, — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 21, 1878
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reg. Officer-VA.Adm.
10b. KIND OF BUSINESS OR INDUSTRY: Govt- Retired
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Frank Williams
14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
INFORMANT: Son — John Williams — Address: Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
332X
DUE TO (b): Generalized Atherosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 20, 1947, to Dec 11, 1959, that I last saw the deceased alive on Nov 28, 1959, 1959, and that death occurred at 2 55 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William L. Howell M.D. — ADDRESS (Street, city or town, state): 5401 Western Ave N.W. Wash DC — DATE SIGNED:

PHYSICIAN'S NAME (Type): William L. HOWELL — 5401 Western Ave. N.W. — 12/12/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/15/59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR — DATE: DEC 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur B. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14001

CERTIFICATE OF DEATH

13972

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LeDeau Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4823 Earleston Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle C. Last WORTHINGTON

4. DATE OF DEATH: Month December Day 21 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 26, 1880
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months 11 Days 25 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Life Insurance salesman -
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George Y. Worthington
14. MOTHER'S MAIDEN NAME: Nancy Taliaferro

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - - - -
16. SOCIAL SECURITY NO.: 579-268-348
INFORMANT: 13308 Okinawa Avenue, Rockville, Md. Mrs. George Dickson - Daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Exsanguination — INTERVAL BETWEEN ONSET AND DEATH: 3 days
572.1
DUE TO
(b) Diverticulitis, Colon — 1 week
DUE TO
(c) ~~Diverticulitis~~ Diverticulosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 19, 1959, to Dec 21, 1959, that I last saw the deceased alive on Dec 21, 1959, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert T. Thibadeau M.D.
ADDRESS (Street, city or town, state): Robert T. Thibadeau, 10609 Concord St. Kensington, Md.
DATE SIGNED: Dec 21, 1959
PHYSICIAN'S NAME (Type): Robert T. Thibadeau, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-24-59
22c. NAME OF CEMETERY OR CREMATORY: Ivy Hill Cemetery
22d. LOCATION (City, town, or county) (State): Alexandria, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: DEC 28 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14002

Reg. Dist. No. 13973

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b: 21 MOS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9638 Dewmar Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
d. STREET ADDRESS: 9638 DEWMAR LA.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle ALBERT Last ZANNER
4. DATE OF DEATH: Month DEC. Day 7 Year 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec 21 1872 86
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JEWELER
10b. KIND OF BUSINESS OR INDUSTRY: PRIVATE
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM ZANNER
14. MOTHER'S MAIDEN NAME: ALWINA WEISS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: A.W. ZANNER S.R. — SAME Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arteriosclerosis — 10 yrs.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic Pulmonary Congestion
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 27, 1950 to Dec 6, 1959 that I last saw the deceased alive on Dec. 2, 1959, and that death occurred at 5:15 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Luther H. Snyder M.D. ADDRESS (Street, city or town, state): 915 - 19th St. N.W. DATE SIGNED: 12/7/59
PHYSICIAN'S NAME (Type): LUTHER H. SNYDER Wash. 6, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 12/10/59
22c. NAME OF CEMETERY OR CREMATORY: Congressional Cem.
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: S H Hines Co. ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR DATE: DEC 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Kime

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2a,b,c * Film G253 12/24/59 iwk

CERTIFICATE OF DEATH

14003

Reg. Dist. No. 13974

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X 2900 Peregow Drive
d. STREET ADDRESS: 3000 McComas Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First: Lydia Middle: G. C. Last: Zingg

4. DATE OF DEATH: Month: 12 Day: 10 Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 12-29-83 ?

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wash. D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Morgan Waters

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Wm J. Coe — Address: 2900 Peregoy Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b) ASCVD — 5 yrs
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to Dec 10, 1959, that I last saw the deceased alive on Dec 9, 1959, and that death occurred at 9:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Horace W. Bernton M.D. — ADDRESS (Street, city or town, state): 10511 Summit Ave — DATE SIGNED: 12/10/59

PHYSICIAN'S NAME (Type): Kensington, Md

1

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12/14/59

22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL

22d. LOCATION (City, town, or county): SUITLAND (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: James T. Ryan Jr. — ADDRESS: 317 Pa. Ave S.E.

24a. REC'D BY REGISTRAR DATE DEC 15 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14004 — 13975 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: D.C — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington — 47X-3
d. STREET ADDRESS: 3100 Brandywine St N.W
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harold — Middle: — Last: Zirkin
4. DATE OF DEATH: Month: Dec. — Day: 27 — Year: 1959

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2.27.05
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fur business
10b. KIND OF BUSINESS OR INDUSTRY: retail
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HYMAN ZIRKIN
14. MOTHER'S MAIDEN NAME: SARAH HARRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife — Address: SAME AS ITEM 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
4.20.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Brosehart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-27-59
EXAMINER'S NAME (Type): FRANK J. BROSEHART

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/30/59
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEORGES CO., MD. (MARYLAND)

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons — ADDRESS: Wash. D.C. 1756 Pa. Ave. N.W.
24a. REC'D BY REGISTRAR — DATE: DEC 29 '59
24b. REGISTRAR'S SIGNATURE: Cirilus S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55